

AL MADALLAH Form



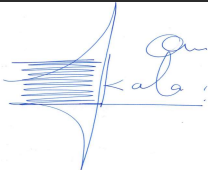
Claim Form

استمارة المطالبة

No:

Please complete all the fields
For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

Date:	22-Dec-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	SHOOQ JAMAL ALI GHANIM ALMAZROUEI		☐ Mr. ☐ Mrs. ☐ Ms.				
Card #	Policy No.	Birth Date :	05-Jun-2003	Sex:	Female		
1340273			dd mm yy				
INFORMATION			To be completed by Physician				
Date of present symptoms:	22/12/2024	Symptom(s) as described by Patient:					
	dd mm yy						
Complaint							
pc: acne conglobata pyoderma eye infection conjunctivitis in both eyes runny nose							
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes				
Chronic Medications:		☐ No	☐ Yes	If Yes Specify			
Family History of any Illness		☐ No	☐ Yes				
OBJECTIVE/ASSESSMENT			To be completed by Physician				
Clinical Finding							
Date	CPT Code	Treatment		Qty	Unit Price		
22-Dec-2024	9	Consultation Gp (General Consultation)		1	60.00		
					60.00		
Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							
Assessment/ Diagnosis			☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected	
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	22-Dec-2024	Enomen Goodluck	H10.13	Acute atopic conjunctivitis, bilateral			Admitting Provider
Primary	22-Dec-2024	Enomen Goodluck	J30.9	Allergic rhinitis, unspecified			Admitting Provider
MEDICAL PLAN							
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim							
☐ Consultation		☐ Physiotherapy		☐ Laboratory		☐ Radiology/Other	
						☐ Pharmacy	
				For Almadallah's Use only			
Pre-authorization Required for:				As per agreed tariff			

Full details of proposed treatment/Surgery/Medicine:		Approval Code:	
IN-PATIENT			
Discharge summary, Itemized Invoices, Report, Results should be attached			
Length of stay:		Provider: ALMadallah GN+ GN RN GOVT POLICE DEWA	Cost:
The above information is true to the best of my knowledge. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical conditions & history to ALMADALLAH for the purpose of determining insurance benefits			
Treating Physician Name: Enomen Goodluck		Patient/Guardian signature	
Tel/Fax: 1234567			
 			
Signature & Stamp:			
Date: 22-12-2024		Date: 22-12-2024	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			