AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة المطالبة

Please complete all the fields

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

No:

Date:	23-Dec-2024	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	Nashwa Fouad Artin	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	21-Sep-1973 *dd mm yy*	**Sex:**	Female		
784-1973-0247919-7							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	23/12/2024 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

co running nose pain in throat dry cough fever on and OFF 20th dec. 2024

oe chest is congested no added sounds

restless

smoker

she is taking thyroid pills 50 mg daily

Pre-existing Condition(s) being treated for :	○ No	○ Yes	If Yes Specify	
Chronic Medications:	○ No	○ Yes		
Family History of any Illness	○ No	○ Yes		

OBJECTIVE/ASSESSMENT ***To be completed by Physician***

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
23-Dec-2024	9	Consultation GP **(General Consultation)**	1	**30.00**
23-Dec-2024	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
23-Dec-2024	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
23-Dec-2024	84443	Thyroid stimulating hormone (TSH) **(Lab)**	1	**32.40**
23-Dec-2024	86140	C-reactive protein; **(Lab)**	1	**12.60**
23-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				115.18

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
Primary	23-Dec-2024	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	23-Dec-2024	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	23-Dec-2024	Humaira	R05	Cough			Admitting Provider
Secondary	23-Dec-2024	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	23-Dec-2024	Humaira	E05.91	Thyrotoxicosis, unspecified with thyrotoxic crisis or storm			Admitting Provider
Secondary	23-Dec-2024	Humaira	J00	Acute nasopharyngitis [common cold]			Admitting Provider

MEDICAL PLAN

Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

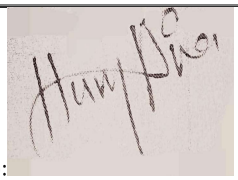
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	**Provider: AL MADALLAH RN4**	**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: Humaira		**Patient/Guardian signature**	
Tel/Fax: 0524244416			
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 23-12-2024		Date: 23-12-2024	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.