AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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:	23-Dec-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	SAMER SHAWKY MOTRAN ARMANYOS	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Oct-1971	Sex:	Male
784-1971-4037258-8			dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	23/12/2024 dd mm yy	Symptom(s) as described by Patient:

Complaint

co body pain joint pain 15th dec. 2024

oe chest is clear no added sounds

restless

diabetic hypertensive

taking already medicine

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	84550	Uric acid; blood (Lab)	1	9.00
23-Dec-2024	86431	Rheumatoid factor; quantitative (Lab)	1	10.80
23-Dec-2024	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
23-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
				65.10

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	M25.50	Pain in unspecified joint			Admitting Provider
Secondary	23-Dec-2024	Humaira	M62.838	Other muscle spasm			Admitting Provider

MEDICAL PLAN

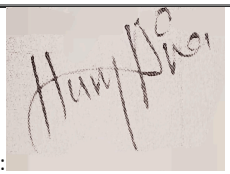
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ 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:  			
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.			