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:** | 24-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 | **Sex:** | Female | | |
| 784-1973-0247919-7 | | | *dd mm yy* | | | | |
| **INFORMATION** | | ***To be completed by Physician*** | | | | | |
| Date of present symptoms: | 24/12/2024 *dd mm yy* | Symptom(s) as described by Patient: | | | | | |
| | | | | | | | |
| 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 |
|---|---|---|---|---|
| 24-Dec-2024 | 9.01 | Follow Up - Consultation GP **(General Consultation)** | 1 | **0.00** |
| 24-Dec-2024 | 94640 | Pressurized or nonpressurized inhalation treatment **(Co.Pay)** | 1 | **14.40** |
| 24-Dec-2024 | 0188-135906-2441 | PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)** | 1 | **10.48** |
| 24-Dec-2024 | 96365 | Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)** | 1 | **46.80** |
| 24-Dec-2024 | 0195-107704-0801 | CEFTRIAXONE-TABUK IV **(Pharmacy)** | 1 | **48.50** |
| | | | | **120.18** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | 24-Dec-2024 | Humaira | J06.9 | Acute upper respiratory infection, unspecified | | | Admitting Provider |
| Secondary | 24-Dec-2024 | Humaira | J30.9 | Allergic rhinitis, unspecified | | | Admitting Provider |
| Secondary | 24-Dec-2024 | Humaira | R05 | Cough | | | Admitting Provider |
| Secondary | 24-Dec-2024 | Humaira | R50.9 | Fever, unspecified | | | Admitting Provider |
| Secondary | 24-Dec-2024 | Humaira | E05.91 | Thyrotoxicosis, unspecified with thyrotoxic crisis or storm | | | Admitting Provider |

## MEDICAL PLAN

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

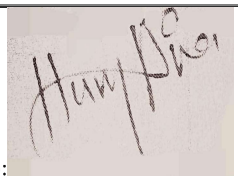
| ☐ Consultation | ☐ Physiotherapy | ☐ Laboratory | ☐ Radiology/Other | ☐ Pharmacy |
|---|---|---|---|---|
| | | | For Almadallah's Use only | |
| Pre-authorization Required for: | | | As per agreed tariff | |
| Full details of proposed treatment/Surgery/Medicine: | | | Approval Code: | |
| | | | | |
| | | | | |

## 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: 24-12-2024 | Date: 24-12-2024 | | |

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