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:	29-Dec-2024	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	ANOOP PARAPPARAMBIL ASOKAN PARAPPARAMBIL KARUNAN RUDRAN ASOKAN	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	23-May-1987	Sex:	Male
784-1987-3865171-4			dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	29/12/2024 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

fever sore throat bodyache for 2 days

no other medical condition

o/e ; hyperemia of pharynx

chest clinically clear

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
29-Dec-2024	9	Consultation GP (General Consultation)	1	30.00
29-Dec-2024	86141	C-reactive protein; high sensitivity (hsCRP) (Lab)	1	24.30
29-Dec-2024	85027	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	12.60
				66.90

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	29-Dec-2024	Humaira	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	29-Dec-2024	Humaira	R50.9	Fever, 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:	

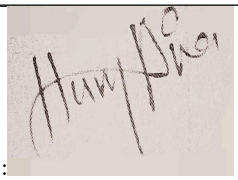
IN-PATIENT

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

Length of stay:	**Provider: 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: 29-12-2024	Date: 29-12-2024
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	