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:	05-Jan-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	NADIR RAJAB ALI MOHAMED RAJAB	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	12-Sep-1992	**Sex:**	Male		
784-1992-0593098-7			*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	05/01/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

co dehydration

vomiting now stop but still weakness 4th jan . 2025

oe chest is clear no added sounds

restless

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
05-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
05-Jan-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
05-Jan-2025	0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION F **(Pharmacy)**	1	**0.90**
05-Jan-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
05-Jan-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : **(Pharmacy)**	1	**5.00**
				77.30

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	05-Jan-2025	Humaira	E86.0	Dehydration			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	05-Jan-2025	Humaira	K52.9	Noninfective gastroenteritis and colitis, unspecified			Admitting Provider
Secondary	05-Jan-2025	Humaira	R11.0	Nausea			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:

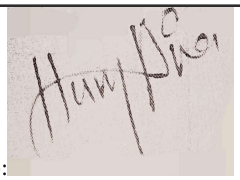
IN-PATIENT

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: 05-01-2025	Date: 05-01-2025
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	