



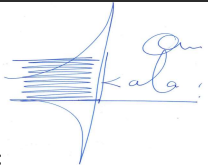
Claim Form

استمارة 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:	08-Jan-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC														
PATIENT INFORMATION																	
Patient's Name (as on card)	MUNEER MUNNADATH PARAMBA		☐ Mr. ☐ Mrs. ☐ Ms.														
Card #	Policy No.	Birth Date :	24-Jan-1974	Sex:	Male												
784-1974-9532507-4			dd mm yy														
INFORMATION			<i>To be completed by Physician</i>														
Date of present symptoms:	08/01/2025	Symptom(s) as described by Patient:															
	dd mm yy																
Complaint																	
for medicine refill.																	
no active complaints.																	
<table border="1"> <tr> <td rowspan="3">Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness</td> <td>☐ No</td> <td>☐ Yes</td> <td rowspan="3">If Yes Specify</td> <td></td> </tr> <tr> <td>☐ No</td> <td>☐ Yes</td> <td></td> </tr> <tr> <td>☐ No</td> <td>☐ Yes</td> <td></td> </tr> </table>							Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness	☐ No	☐ Yes	If Yes Specify		☐ No	☐ Yes		☐ No	☐ Yes	
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	☐ No	☐ Yes															
	☐ No	☐ Yes															
OBJECTIVE/ASSESSMENT			<i>To be completed by Physician</i>														
Clinical Finding																	
Date	CPT Code	Treatment	Qty	Unit Price													
08-Jan-2025	9	Consultation GP (General Consultation)	1	30.00													
				30.00													
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	08-Jan-2025	Enomen Goodluck	I10	Essential (primary) hypertension			Admitting Provider										
Secondary	08-Jan-2025	Enomen Goodluck	E11.9	Type 2 diabetes mellitus without complications			Admitting Provider										
MEDICAL PLAN																	
<i>Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim</i>																	
☐ Consultation		☐ Physiotherapy		☐ Laboratory		☐ Radiology/Other											
						☐ Pharmacy											
Pre-authorization Required for:			For Almadallah's Use only														
Full details of proposed treatment/Surgery/Medicine:			As per agreed tariff														
			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: Enomen Goodluck		Patient/Guardian signature	
Tel/Fax: 1234567			
Signature & Stamp: 			
Date: 08-01-2025		Date: 08-01-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			