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:	10-Jan-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	ADNAN SAQIB MUHAMMAD ABDUL QADIR KHAN		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	12-Apr-1979 dd mm yy	Sex:	Male	
784-1979-5215815-8							
INFORMATION			*To be completed by Physician*				
Date of present symptoms:	10/01/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

PC: Cupious runny nose, repeated sneezing

Has history of allergic rhinitis and sinusitis.

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
10-Jan-2025	9	Consultation GP (General Consultation)	1	30.00
10-Jan-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	2	9.00
10-Jan-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE (Pharmacy)	1	2.34
10-Jan-2025	0005-111805-1021	CHLOROHISTOL 10MG (Pharmacy)	1	1.20
				42.54

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	10-Jan-2025	Enomen Goodluck	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	10-Jan-2025	Enomen Goodluck	R06.7	Sneezing			Admitting Provider
Secondary	10-Jan-2025	Enomen Goodluck	R09.81	Nasal congestion			Admitting Provider

MEDICAL PLAN

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

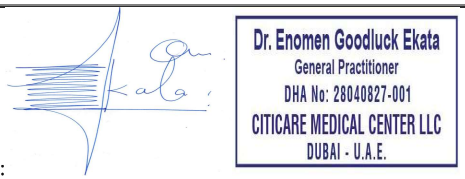
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: 			
Date: 10-01-2025	Date: 10-01-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			