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:	11-Jan-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	VERONIKA LAPINA	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	07-Aug-1996	Sex:	Female		
784-1996-8809049-9			dd mm yy				
INFORMATION		To be completed by Physician					
Date of present symptoms:	11/01/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint
pc : swollen face , puffy eyes, dry skin for 1 day

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
11-Jan-2025	9	Consultation GP (General Consultation)	1	30.00
11-Jan-2025	85027	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	12.60
11-Jan-2025	80076	Hepatic function panel This panel must include the (Lab)	1	77.40
11-Jan-2025	80053	Comprehensive metabolic panel This panel must incl (Lab)	1	103.50
11-Jan-2025	86141	C-reactive protein; high sensitivity (hsCRP) (Lab)	1	24.30
				247.80

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	11-Jan-2025	DR Amaizah	R21	Rash and other nonspecific skin eruption			Admitting Provider
Secondary	11-Jan-2025	DR Amaizah	L99	Oth disorders of skin, subcu in diseases classd elswhr			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: DR Amaizah		**Patient/Guardian signature**	
Tel/Fax: 0561012068			
Signature & Stamp:  			
Date: 11-01-2025	Date: 11-01-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			