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:	12-Jan-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	ABDUL ARIF BABU BABU	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	12-Jun-1976 *dd mm yy*	**Sex:**	Male		
784-1976-2571744-8							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	12/01/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

PC: Pain on the posterior neck that radiates to the left arm, with associated tingling and numbness that is more pronounced on the posterior surface of the hand especially the thumb.

Duration: 12 days (01/01/2025).

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
12-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	12-Jan-2025	Enomen Goodluck	M47.892	Other spondylosis, cervical region			Admitting Provider
Secondary	12-Jan-2025	Enomen Goodluck	M54.2	Cervicalgia			Admitting Provider
Secondary	12-Jan-2025	Enomen Goodluck	R52	Pain, 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

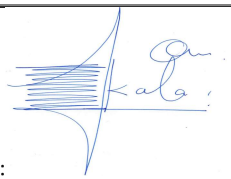
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: Enomen Goodluck		**Patient/Guardian signature**	

Tel/Fax: 1234567

Signature & Stamp:



Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Date: 12-01-2025	Date: 12-01-2025

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.