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:	13-Jan-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	SAMER SHAWKY MOTRAN ARMANYOS	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Oct-1971 (dd mm yy)	Sex:	Male
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INFORMATION

To be completed by Physician

Date of present symptoms:	13/01/2025 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

pc : dry cough for few days not associated with fever , throat irritation for few day ,

myalgia , sensory sensations altered

known diabetic for many years

knwn htn on meds

o/e ; slight hyperemia of pharynx

chest is clear

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
13-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	13-Jan-2025	SANDIA	E11.3312	Type 2 diab with mod nonp rtnop with macular edema, l eye			Admitting Provider
Secondary	13-Jan-2025	SANDIA	R05	Cough			Admitting Provider

MEDICAL PLAN

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

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

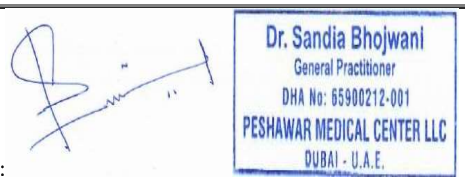
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

IN-PATIENT

Discharge summary, Itemized Invoices, Report, Results should be attached

Length of stay:	**Provider: ALMADALLAH HEALTHCARE MANAGEMENT FZ-LLC**	**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: SANDIA		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: 			
Date: 13-01-2025	Date: 13-01-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			