AL MADALLAH Form

almadallah
Healthcare Management

Claim Form

استمـــارة 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:	15-Jan-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	JAVAD MOHAMMED KOOLERI VALIYA PURAYIL KUNHI	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	18-Mar-1992	**Sex:**	Male
784-1992-7070917-5			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	15/01/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc : sorethroat , nasal blockage , cough dry fever ,headache for few days

smokes tobacco

bp is elevated

no other med conditions

ole : hyperemia of pharynx

chest congested

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
15-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
				162.78

Date	CPT Code	Treatment	Qty	Unit Price
15-Jan-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
15-Jan-2025	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
15-Jan-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
15-Jan-2025	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
15-Jan-2025	85027	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**12.60**
				162.78

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	15-Jan-2025	SANDIA	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	15-Jan-2025	SANDIA	J20.9	Acute bronchitis, unspecified			Admitting Provider
Secondary	15-Jan-2025	SANDIA	J45.991	Cough variant asthma			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: SANDIA		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: Dr. Sandia Bhojwani General Practitioner DHA No: 65900212-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 15-01-2025	Date: 15-01-2025		

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