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:	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 *dd mm yy*	**Sex:**	Male
784-1992-7070917-5					

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:

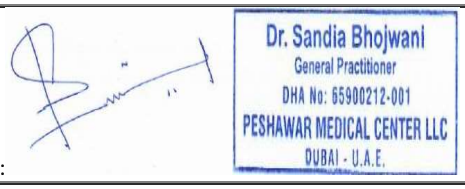
IN-PATIENT

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: 	
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.