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:	16-Jan-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)		CHARMAIGNE DE LEON SALAZAR	○ Mr. ○ Mrs. ○ Ms.				
Card #		Policy No.	Birth Date :	06-Sep-1990	Sex:	Female	
784-1990-9320948-6				dd mm yy			
INFORMATION			To be completed by Physician				
Date of present symptoms:	16/01/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

pc : painfu defecation , itchinng at anus , hemorrhoids ,external , fever for 1 week

known hypertension on meds

chronic constipation and chronic cough

o/e dilated sryctures around anus , redish in color , tensder

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
16-Jan-2025	85027	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**14.40**
16-Jan-2025	9	Consultation GP **(General Consultation)**	1	**35.00**
16-Jan-2025	96374	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**12.60**
16-Jan-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**54.00**
16-Jan-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
16-Jan-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
				172.90

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	16-Jan-2025	SANDIA	K59.04	Chronic idiopathic constipation			Admitting Provider
Secondary	16-Jan-2025	SANDIA	R50.9	Fever, unspecified			Admitting Provider
Secondary	16-Jan-2025	SANDIA	R10.30	Lower abdominal pain, unspecified			Admitting Provider
Secondary	16-Jan-2025	SANDIA	N39.0	Urinary tract infection, site not specified			Admitting Provider

MEDICAL PLAN

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

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

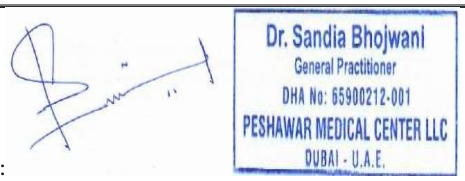
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

IN-PATIENT

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

Length of stay:	**Provider: AL MADALLAH RN3**	**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: 16-01-2025		Date: 16-01-2025	

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