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

PATIENT INFORMATION

Patient's Name (as on card)	KHOKAN SARKER BAKUL SARKER	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	04-Aug-1980	Sex:	Male
784-1980-9693064-3			dd mm yy		

INFORMATION

To be completed by Physician

Date of present symptoms:	18/01/2025 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

co headache increase in blood pressure with out diagnosis of htn 11th dec. 2024

oe chest is clear no added sounds

restless

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
18-Jan-2025	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00
				0.00

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	18-Jan-2025	SANDIA	I10	Essential (primary) hypertension			Admitting Provider
Secondary	18-Jan-2025	SANDIA	E78.5	Hyperlipidemia, unspecified			Admitting Provider

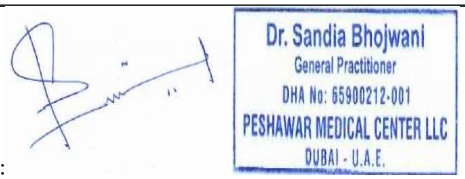
MEDICAL PLAN

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: SANDIA		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: 			
Date: 18-01-2025	Date: 18-01-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			