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:	19-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	
784-1971-4037258-8							
INFORMATION			*To be completed by Physician*				
Date of present symptoms:	19/01/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

c : 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 clea

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
19-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
19-Jan-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
19-Jan-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				57.90

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	19-Jan-2025	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	19-Jan-2025	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	19-Jan-2025	Humaira	R05	Cough			Admitting Provider
Secondary	19-Jan-2025	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	19-Jan-2025	Humaira	K29.00	Acute gastritis without bleeding			Admitting Provider

MEDICAL PLAN

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

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

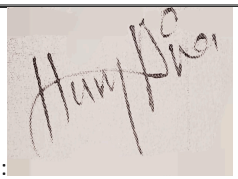
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: Humaira		**Patient/Guardian signature**	
Tel/Fax: 0524244416			
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 19-01-2025		Date: 19-01-2025	

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