## 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:** 19-Jan-2025 | **Healthcare Provider:** | CITICARE MEDICAL CENTER LLC | | | | |
| **PATIENT INFORMATION** | | | | | | |
| **Patient's Name (as on card)** | ISHTIAQ AHMAD MEHTAB DIN | ○ Mr. ○ Mrs. ○ Ms. | | | | |
| Card # | Policy No. | Birth Date : | 12-Sep-1992 | **Sex:** | Male | |
| 784-1992-2641417-7 | | | *dd mm yy* | | | |
| **INFORMATION** | | ***To be completed by Physician*** | | | | |
| Date of present symptoms: | 19/01/2025 *dd mm yy* | Symptom(s) as described by Patient: | | | | |

**Complaint**

co skin allergy all over the body redness 1 month 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 |
|---|---|---|---|---|
| | | | | **187.80** |

| Date | CPT Code | Treatment | Qty | Unit Price |
|---|---|---|---|---|
| 19-Jan-2025 | 9 | Consultation GP **(General Consultation)** | 1 | **30.00** |
| 19-Jan-2025 | 96372 | Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)** | 1 | **9.00** |
| 19-Jan-2025 | 0005-111805-1021 | CHLOROHISTOL 10MG **(Pharmacy)** | 1 | **1.20** |
| 19-Jan-2025 | 80069 | Renal function panel This panel must include the f **(Lab)** | 1 | **90.90** |
| 19-Jan-2025 | 80061 | Lipid panel This panel must include the following: **(Lab)** | 1 | **44.10** |
| 19-Jan-2025 | 86003 | Allergen specific IgE; quantitative or semiquantit **(Lab)** | 1 | **12.60** |
| | | | | **187.80** |

| 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 | R03.0 | Elevated blood-pressure reading, w/o diagnosis of htn | | | Admitting Provider |
| Secondary | 19-Jan-2025 | Humaira | R21 | Rash and other nonspecific skin eruption | | | Admitting Provider |
| Secondary | 19-Jan-2025 | Humaira | T78.40XA | Allergy, unspecified, initial encounter | | | Admitting Provider |
| Secondary | 19-Jan-2025 | Humaira | E78.5 | Hyperlipidemia, unspecified | | | Admitting Provider |
| Secondary | 19-Jan-2025 | Humaira | R34 | Anuria and oliguria | | | 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** | |

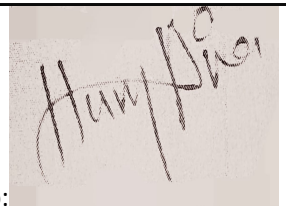
| | | |
|---|---|---|
| Pre-authorization Required for: | | As per agreed tariff |
| Full details of proposed treatment/Surgery/Medicine: | | Approval Code: |
| | | |
| | | |

## 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.