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

PATIENT INFORMATION

Patient's Name (as on card)	MANLIKA LERSLAE	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	30-Aug-1990 (dd mm yy)	Sex:	Female
2058643					

INFORMATION

To be completed by Physician

Date of present symptoms:	20/01/2025 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

sore throat,pain in throat,minor headache,cold,minor body pain

o/e there is swelling and white patches over tonsils

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
20-Jan-2025	9	Consultation GP (General Consultation)	1	30.00
				30.00

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

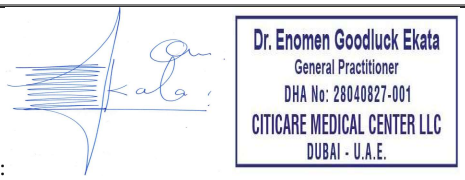
Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	20-Jan-2025	Enomen Goodluck	J03.90	Acute tonsillitis, unspecified			Admitting Provider
Secondary	20-Jan-2025	Enomen Goodluck	R52	Pain, unspecified			Admitting Provider
Secondary	20-Jan-2025	Enomen Goodluck	R09.81	Nasal congestion			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: Enomen Goodluck		**Patient/Guardian signature**	
Tel/Fax: 1234567			
Signature & Stamp: 			
Date: 20-01-2025		Date: 20-01-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			