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:	21-Jan-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Nashwa Fouad Artin	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	21-Sep-1973 *dd mm yy*	**Sex:**	Female
784-1973-0247919-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	21/01/2025 *dd mm yy*	Symptom(s) as described by Patient:		
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
21-Jan-2025	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
21-Jan-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
21-Jan-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
21-Jan-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
21-Jan-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
				110.80

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
No Diagnosis History Found							

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:

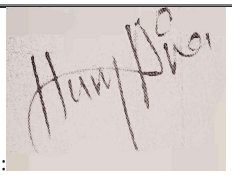
IN-PATIENT

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:  	
Date: 21-01-2025	Date: 21-01-2025
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	