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)	SAMER SHAWKY MOTRAN ARMANYOS	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Oct-1971	Sex:	Male
784-1971-4037258-8			dd mm yy		

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	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
21-Jan-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00
21-Jan-2025	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00
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
				165.80

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	21-Jan-2025	Humaira	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	21-Jan-2025	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	21-Jan-2025	Humaira	R05	Cough			Admitting Provider
Secondary	21-Jan-2025	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	21-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

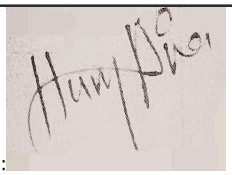
Length of stay:	**Provider: AL MADALLAH RN4**	**Cost:**

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: 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.