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)	LITTO VARGHESE	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	30-May-1988	Sex:	Male
784-1988-9806024-3	IM233EA		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:

Complaint

Medication refill.

Has nil fresh complaint.

Known hypertensive controlled on lorsartan

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	Consultation GP (General Consultation)	1	30.00
21-Jan-2025	80069	Renal function panel This panel must include the f (Lab)	1	90.90
21-Jan-2025	80061	Lipid panel This panel must include the following: (Lab)	1	44.10
				165.00

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	21-Jan-2025	Humaira	I10	Essential (primary) hypertension			Admitting Provider
Secondary	21-Jan-2025	Humaira	Z79.899	Other long term (current) drug therapy			Admitting Provider
Secondary	21-Jan-2025	Humaira	E78.5	Hyperlipidemia, unspecified			Admitting Provider
Secondary	21-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

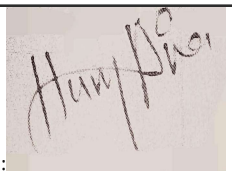
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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:  			
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.