AL MADALLAH Form



Claim Form استمارة المطالبة

No:	
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Please complete all the fields For Pre Approval kindly call our Help Line for 24 hours: 04 559 1322 Fax: +9714 434 2310

Policy No.	Date:	28-Jan-202	25	Healthcare Provider: CITICARE MEDICAL CENTER LLC										
Policy No. Policy Physician	PATII	ENT INF	FORMA	ΓΙΟΝ	1									
Secondary Seco	Patient's Name (as on card)			MUHAMMAD ADNAN FAZAL REHMAN				OMr. OMrs. OMs.						
Male Internation Male	Card #			Policy	No.					01-Jan-				
Date of Present symptoms: 2801/2025	784-1987-0462425-7			IM23	7EA NLSB				Birth Date :			1	Male	
Date of present symptoms: Symptom(s) as described by Patient:	INFO	RMATI	ON						To be completed by I	Physician			1	
Symptom(s) as described by Patient: Symptom(s) as described by Pat				28/01	/2025									
Complaint pc: body pain , muscle pain , weakness low vitain d and vitamin b prteviously	Date of	present syn	nptoms:				Symptom(s)	Symptom(s) as described by Patient:						
Doctor Consultation Dental Dent														
Topic Consultation Prescriptions Prescriptions Prescriptions Prescription Prescrip	Complaint													
Topic Consultation Prescriptions Prescriptions Prescriptions Prescription Prescrip	*													
Pre-existing Condition(s) being treated for: No	pc: b	ody pain, r	nuscle pain	, weak	ness									
Pre-existing Condition(s) being treated for: No														
Pre-existing Condition(s) being treated for: No	low vi	itain d and v	itamin b pr	tevious	slv									
Pre-existing Condition(s) being treated for: Chronic Medicans: Family History of any Illness No														
Pre-existing Condition(s) being treated for: Chronic Medicans: Family History of any Illness No														
Chronic Medications: Family History of any Illness No							○ No		○Yes					
No Yes To be completed by Physician				g treate	d for :		ONo		○Yes	If Yes				
Date CPT Code Treatment Qty Unit Price 28-Jan-2025 9 Consultation GP (General Consultation) 1 30.00 Cause Physical Illness Accident Maternity Preventive Psychiatric Dental Work Related Other(s) Explain Assessment/ Diagnosis Accident ICD Code Diagnosis Notes year Problem Role Primary 28-Jan-2025 DR Amaizah G72.9 Myopathy, unspecified Admitting Provider Secondary 28-Jan-2025 DR Amaizah M54.5 Low back pain Admitting Provider Secondary 28-Jan-2025 DR Amaizah M62.838 Other muscle spasm Admitting Provider MEDICAL PLAN Memized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim Consultation Physiotherapy Laboratory Radiology/Other Pharmacy Pre-authorization Required for: Approval Code: N-PATIENT Discharge summary, Hemized Invoices, Report, Results should be attached Length of Stay: Provider: AL MADALLAH RN4 Cost: Provider:	Family 1	History of a	ny Illness				O N a		OVer	Specify				
Clinical Finding	OBJEC	NEW TELL CO	ECC AENT	D.			○ No			D7 · ·	l			
Date CPT Code Treatment Qty Unit Price 28-Jan-2025 9 Consultation GP (General Consultation) 1 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 28-Jan-2025 DR Amaizah G72.9 Myopathy, unspecified Admitting Provider Secondary 28-Jan-2025 DR Amaizah M54.5 Low back pain Admitting Provider Secondary 28-Jan-2025 DR Amaizah M62.838 Other muscle spasm Admitting Provider MEDICAL PLAN Memized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim Consultation Physiotherapy Laboratory Radiology/Other Pharmacy Pre-authorization Required for: Approval Code: Full details of proposed treatment/Surgery/Medicine: Approval Code: N-PATTENT			ESSMEN	L					10 be completed by I	Pnysician				
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Cause											Qij		III I I I I I	
Cause Physical Illness Accident Maternity Preventive Psychiatric Dental Work Related	28-Jar	n-2025	9					ion)			1			30.00
Other(s) Explain Acute			1											30.00
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Assessment/ Diagnosis Acute	Oth	er(s) Expla	in							рзуста	ire			
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nformation regarding my medical conditions & history to ALMADALLAH for the purpose of determining insurance benefits	The abo	ve informa						rize any H	lealthcare Provider, In	nsurer, Emp	oloyer or	other	Organization to rele	ease any
	informa	tion regardi	ng my med	ical co	nditions & hist	ory to AL	MADALLA	M for the	purpose of determini	ing insuran	ce benefi	ts		

Treating Physician Name: DR Amaizah				Patient/Guardian signature	
Tel/Fax: 0561012068				,	
Signature & Stamp:	Dr. Amaizah Ishtia General Praciitioner Dha: 98486553-001 Citicare Medical Cen Dubai - U.A.E	'			
Date: 28-01-2025		Date: 28-01-2025			
Claims should be submitted with supporting	documents within	30 days from date of	service or as per contra	ect.	·