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

PATIENT INFORMATION

Patient's Name (as on card)	ADEL MAHDI MOHAMMAD ALHUMSI	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	16-Jun-1992 *dd mm yy*	**Sex:**	Male
784-1992-5977831-6					

INFORMATION

To be completed by Physician

Date of present symptoms:	28/01/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc : pain and swelling of oral mucosa

,o/e

pallor

fibrosis of oral mucosa

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
28-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
28-Jan-2025	86141	C-reactive protein; high sensitivity (hsCRP) **(Lab)**	1	**24.30**
28-Jan-2025	85027	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**12.60**
				66.90

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	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	28-Jan-2025	DR Amaizah	R05	Cough			Admitting Provider

MEDICAL PLAN

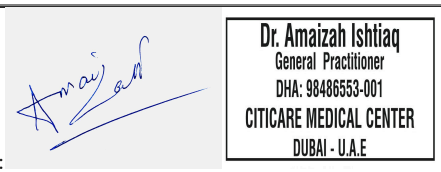
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: DR Amaizah		**Patient/Guardian signature**	
Tel/Fax: 0561012068			
Signature & Stamp: 			
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 contract.			