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)	Shahid Mahmood Muhammad Sharif	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	20-Feb-1986	**Sex:**	Male	
784-1986-9454300-4			*dd mm yy*			
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	28/01/2025 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

came for fertility issues

fertility supplements refil

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
				30.00

Date	CPT Code	Treatment	Qty	Unit Price
28-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
				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
Secondary	28-Jan-2025	DR Amaizah	R53.1	Weakness			Admitting Provider
Primary	28-Jan-2025	DR Amaizah	M79.661	Pain in right lower leg			Admitting Provider
Secondary	28-Jan-2025	DR Amaizah	M54.5	Low back pain			Admitting Provider
Secondary	28-Jan-2025	DR Amaizah	E11.9	Type 2 diabetes mellitus without complications			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:

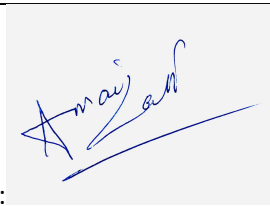
IN-PATIENT

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:  Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER 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 contract.	