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

PATIENT INFORMATION

Patient's Name (as on card)	SOE MI MI TUN	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	10-May-1994 (dd mm yy)	**Sex:**	Female
784-1994-1222739-1					

INFORMATION

To be completed by Physician

Date of present symptoms:	30/01/2025 (dd mm yy)	Symptom(s) as described by Patient:

Complaint

pt com[lains of dizziness , headachesince 2 days.

eating and drinking well.

dizziness disturbs sleeping

no nausea or vomiting

pt looks pale, dehydrated and ill.

o/e chest is clear

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-Jan-2025	0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P. **(Pharmacy)**	1	**4.50**
30-Jan-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
30-Jan-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
30-Jan-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
				82.20

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	30-Jan-2025	SANDIA	R51.9	Headache, unspecified			Admitting Provider
Primary	30-Jan-2025	SANDIA	E86.0	Dehydration			Admitting Provider

MEDICAL PLAN

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

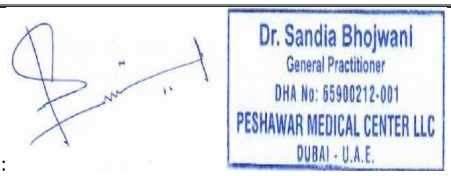
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: SANDIA		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: 			
Date: 30-01-2025	Date: 30-01-2025		

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.