

AL MADALLAH Form



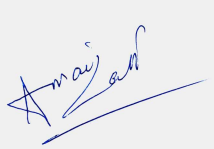
Claim Form

استمارة 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)	MOHAMED HAMDY MOHAMED KHODEIR		☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	06-May-1986	Sex:	Male	
784-1986-5828590-7			dd mm yy			
INFORMATION						
<i>To be completed by Physician</i>						
Date of present symptoms:	30/01/2025	Symptom(s) as described by Patient:				
	dd mm yy					
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes			
Chronic Medications:		☐ No	☐ Yes	If Yes Specify		
Family History of any Illness		☐ No	☐ Yes			
OBJECTIVE/ASSESSMENT						
<i>To be completed by Physician</i>						
Clinical Finding						
Date	CPT Code	Treatment			Qty	Unit Price
30-Jan-2025	9.01	Follow Up - Consultation GP (General Consultation)			1	0.00
30-Jan-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)			2	9.00
30-Jan-2025	0195-107704-0802	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk (Pharmacy)			1	48.50
30-Jan-2025	0318-267101-0801	HYDROCORTISONE-Solu-Cortef (Pharmacy)			1	16.00
30-Jan-2025	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)			1	10.48
30-Jan-2025	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)			1	14.40
						98.38
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
Primary	30-Jan-2025	DR Amaizah	J02.9	Acute pharyngitis, unspecified		
Secondary	30-Jan-2025	DR Amaizah	R50.9	Fever, unspecified		
MEDICAL PLAN						
<i>Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim</i>						
☐ 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: 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.								