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:	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		***To be completed by Physician***				
Date of present symptoms:	30/01/2025 *dd mm yy*	Symptom(s) as described by Patient:				
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	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	Problem Role
Primary	30-Jan-2025	DR Amaizah	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	30-Jan-2025	DR Amaizah	R50.9	Fever, unspecified			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: 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.			