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:	15-Feb-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	MAGED MOHAMED ELSAYEH IBRAHIM		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	16-May-1983 *dd mm yy*	**Sex:**	Male	
784-1983-5902651-9							
INFORMATION			***To be completed by Physician***				
Date of present symptoms:	15/02/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

patient came for generalize weakness .diarrhea .and body pain

khnown case of asthma

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
15-Feb-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
15-Feb-2025	96374	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
15-Feb-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
15-Feb-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
15-Feb-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
15-Feb-2025	0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P. **(Pharmacy)**	1	**4.50**
15-Feb-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
15-Feb-2025	0131-116601-1001	METRONIDAZOLE-Metronidazole **(Pharmacy)**	1	**9.50**
15-Feb-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
				157.90

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	15-Feb-2025	Humaira	R52	Pain, unspecified			Admitting Provider
Secondary	15-Feb-2025	Humaira	R19.7	Diarrhea, unspecified			Admitting Provider
Secondary	15-Feb-2025	Humaira	R10.9	Unspecified abdominal pain			Admitting Provider
Secondary	15-Feb-2025	Humaira	R05	Cough			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	15-Feb-2025	Humaira	R50.9	Fever, unspecified			Admitting Provider

MEDICAL PLAN

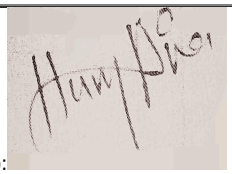
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: Humaira		**Patient/Guardian signature**	
Tel/Fax: 0524244416			
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 15-02-2025	Date: 15-02-2025		

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