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:	23-Feb-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	HASSAN BILAL NOOR	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	15-Apr-2000	**Sex:**	Male		
784-2000-6939030-8			*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	23/02/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

PC ; PAIN , SWELLING AND REDNESS OF LEFT GREAT TOE

20/01/25

ASSOCITAED WITH LOW GRADE FEVER STARTED 20/02/25

INGROWN TOE NAIL LEFT FOOT

O/E : BLEDING FROM SURROUNDING TISSUES , SWOLLEN HOT AND TENDER

RT GREAT TOE

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
23-Feb-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
23-Feb-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**9.00**
23-Feb-2025	0195-107704-0802	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk **(Pharmacy)**	1	**48.50**
23-Feb-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
23-Feb-2025	11750	Excision of nail and nail matrix, partial or compl **(Co.Pay)**	1	**429.30**
				523.30

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	23-Feb-2025	DR Amaizah	L60.0	Ingrowing nail			Admitting Provider
Secondary	23-Feb-2025	DR Amaizah	R21	Rash and other nonspecific skin eruption			Admitting Provider
Secondary	23-Feb-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	23-Feb-2025	DR Amaizah	R50.9	Fever, unspecified			Admitting Provider
Secondary	23-Feb-2025	DR Amaizah	L03.032	Cellulitis of left toe			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: 23-02-2025	Date: 23-02-2025

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