



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:	27-Feb-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC		
PATIENT INFORMATION					
Patient's Name (as on card)	Naraumon Chantachaem Chantachaem		☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	11-Nov-1990	Sex: Female	
784-1990-1506213-8		dd mm yy			
INFORMATION		To be completed by Physician			
Date of present symptoms:	27/02/2025	Symptom(s) as described by Patient:			
	dd mm yy				
Complaint					
PC : SORE THROAT ., SNEEZING , WATERY EYES , RUNNY NOSE , COUGH WITH SPUTUM ASSOCIATED WITH FEVER					
O/E : LOOK PALE					
DEHYDRATED					
HYPEEMIC PHARYNX					
CHEST WHEEZING					
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		To be completed by Physician			
Clinical Finding					
Date	CPT Code	Treatment	Qty	Unit Price	
27-Feb-2025	9	Consultation GP (General Consultation)	1	30.00	
27-Feb-2025	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80	
27-Feb-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00	
27-Feb-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP (Pharmacy)	1	5.00	
27-Feb-2025	96360	Intravenous infusion, hydration; initial, 31 minut (Co.Pay)	1	32.40	
27-Feb-2025	86140	C-reactive protein; (Lab)	1	12.60	
27-Feb-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30	
27-Feb-2025	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)	1	10.48	
27-Feb-2025	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40	
27-Feb-2025	0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 M (Pharmacy)	1	1.20	
27-Feb-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)	1	8.40	
				234.08	

Date	CPT Code	Treatment	Qty	Unit Price
27-Feb-2025	0195-107704-0801	CEFTRIAZONE-TABUK IV (Pharmacy)	1	48.50
				234.08

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	27-Feb-2025	DR Amaizah	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	27-Feb-2025	DR Amaizah	J45.991	Cough variant asthma			Admitting Provider
Secondary	27-Feb-2025	DR Amaizah	R50.9	Fever, unspecified			Admitting Provider
Secondary	27-Feb-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider
Secondary	27-Feb-2025	DR Amaizah	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:
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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	
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Tel/Fax: 0561012068

 Signature & Stamp: Date: 27-02-2025	 Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	Date: 27-02-2025
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Claims should be submitted with supporting documents within 30 days from date of service or as per contract.