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-Mar-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	ANOOP PARAPPARAMBIL ASOKAN PARAPPARAMBIL KARUNAN RUDRAN ASOKAN	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	23-May-1987	**Sex:**	Male	
784-1987-3865171-4			*dd mm yy*			
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	15/03/2025 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

pc : pain , bleding from finger

o/e : laceration of 3*3 cm which is bleeding perfusly

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-Mar-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
15-Mar-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
15-Mar-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
15-Mar-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
15-Mar-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
15-Mar-2025	12002	Simple repair of superficial wounds of scalp, neck **(Co.Pay)**	1	**233.10**
				316.00

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-Mar-2025	DR Amaizah	S61.318S	Laceration w/o fb of finger w damage to nail, sequela			Admitting Provider
Secondary	15-Mar-2025	DR Amaizah	R52	Pain, 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: 15-03-2025	Date: 15-03-2025

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