



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:	18-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				<i>To be completed by Physician</i>			
Date of present symptoms:	18/03/2025	Symptom(s) as described by Patient:					
dd mm yy							
Complaint							
pc : hx of injury with kitchen knife while he was sharpening knife on 18/03/25 presented with perfuse bleeding from wound and severe pain which is 7 on pain scale started 18/03/25 associated with feeling dizzy with cold and low blood pressure 18/03/25 o/e : look plae , week pulse , cold periphery low blood pressure 90/60 mmhg 3*3 cm lacerated wound on left hand medial half involving little finger without foreign body with perfuse bleeding on							
Pre-existing Condition(s) being treated for :				☐ No	☐ Yes		
Chronic Medications:				☐ No	☐ Yes	If Yes	
Family History of any Illness				☐ No	☐ Yes	Specify	
OBJECTIVE/ASSESSMENT				<i>To be completed by Physician</i>			
Clinical Finding							
Date	CPT Code	Treatment	Qty	Unit Price			
18-Mar-2025	9	Consultation GP (General Consultation)	1	30.00			
18-Mar-2025	96360	Intravenous infusion, hydration; initial, 31 minut (Co.Pay)	1	32.40			
18-Mar-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP (Pharmacy)	1	5.00			
18-Mar-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00			
18-Mar-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)	1	6.50			
18-Mar-2025	12042	Repair, intermediate, wounds of neck, hands, feet (Co.Pay)	1	510.30			
				593.20			
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	18-Mar-2025	DR Amaizah	S61.218S	Laceration w/o fb of finger w/o damage to nail, sequela			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	S61.412A	Laceration without foreign body of left hand, init encntr			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	L03.90	Cellulitis, unspecified			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	R03.1	Nonspecific low blood-pressure reading			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

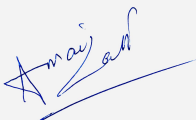
Length of stay:	Provider: AL MADALLAH RN4	Cost:
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The above information is true to the best of my knowledge. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical conditions & 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:	
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Dr. Amaizah Ishtiaq
 General Practitioner
 DHA: 98486553-001
 CITICARE MEDICAL CENTER
 DUBAI - U.A.E

Date: 18-03-2025

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