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:	19-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 *dd mm yy*	**Sex:**	Male
784-1987-3865171-4					

INFORMATION

To be completed by Physician

Date of present symptoms:	19/03/2025 *dd mm yy*	Symptom(s) as described by Patient:

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	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
19-Mar-2025	12042	Repair, intermediate, wounds of neck, hands, feet **(Co.Pay)**	1	**510.30**
19-Mar-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
19-Mar-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
19-Mar-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
19-Mar-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
19-Mar-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
				593.20

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
No Diagnosis History Found							

MEDICAL PLAN

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

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

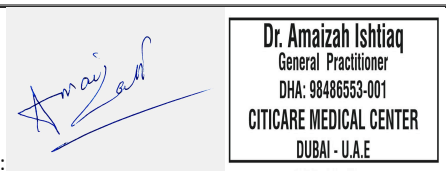
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: 19-03-2025	Date: 19-03-2025		

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