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:	20-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:	20/03/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

PAME FOR FOLLOW UP

HISTORY OF INJURY WITH KITCHEN KNIFE 2 DAYS BACK

NO PAIN .

HE NEEDS DRESSING

ADVICE TO COME AFTER 5 DAYS

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
20-Mar-2025	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
20-Mar-2025	16020	Dressings and/or debridement of partial-thickness **(Co.Pay)**	1	**145.80**
20-Mar-2025	51.01	Non-surgical cleansing of a wound without debridem **(General Consultation)**	1	**13.50**
				159.30

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	20-Mar-2025	AISHA	S01.01XA	Laceration without foreign body of scalp, initial encounter			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:

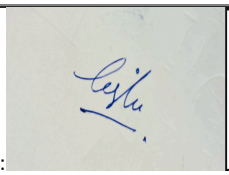
IN-PATIENT

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: AISHA		**Patient/Guardian signature**	

Tel/Fax:	
Signature & Stamp:  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	
Date: 20-03-2025	Date: 20-03-2025

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