AL MADALLAH Form

almadallah Healthcare Management

Claim Form

استمـــارة 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:	22-Mar-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	FARHAT HAMID HAMID KARIM KHAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	01-Apr-1964 *dd mm yy*	**Sex:**	Female		
784-1964-1336932-1							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	22/03/2025 *dd mm yy*	Symptom(s) as described by Patient:					
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
22-Mar-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
22-Mar-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
22-Mar-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
22-Mar-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	3	**9.00**
22-Mar-2025	0188-135906-2441	PULMICORT **(Pharmacy)**	1	**10.48**
22-Mar-2025	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
22-Mar-2025	0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 M **(Pharmacy)**	1	**1.20**
22-Mar-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 **(Pharmacy)**	1	**2.34**
22-Mar-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
22-Mar-2025	0195-107704-0802	CEFTRIAXONE-TABUK IM **(Pharmacy)**	1	**48.50**
				161.72

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	22-Mar-2025	DR Amaizah	J03.90	Acute tonsillitis, unspecified			Admitting Provider
Secondary	22-Mar-2025	DR Amaizah	R05	Cough			Admitting Provider
Secondary	22-Mar-2025	DR Amaizah	R50.9	Fever, 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:

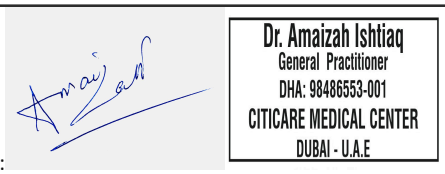
IN-PATIENT

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: 	
Date: 22-03-2025	Date: 22-03-2025
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	