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:	02-Apr-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	Arunima Anthikkat Karunaprakash	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	29-May-1996 *dd mm yy*	**Sex:**	Female	
784-1996-6672894-6						
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	02/04/2025 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

PC : SORE THROAT , BODYPAIN , SNEEZING , NASAL CONGESTION , WATERY EYES AND LOW GRADE FEVER

STARTED 30/03/25

O/E : HYPEREMIC PHARYNX

CHST CONGESTED

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
02-Apr-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
02-Apr-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
02-Apr-2025	96374	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
02-Apr-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
02-Apr-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
02-Apr-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
02-Apr-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
02-Apr-2025	0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 M **(Pharmacy)**	1	**1.20**
02-Apr-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
02-Apr-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
02-Apr-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
				196.50

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	02-Apr-2025	DR Amaizah	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	02-Apr-2025	DR Amaizah	R05	Cough			Admitting Provider
Secondary	02-Apr-2025	DR Amaizah	J30.9	Allergic rhinitis, unspecified			Admitting Provider

MEDICAL PLAN

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

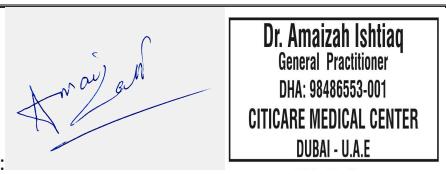
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 02-04-2025		Date: 02-04-2025	

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