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:	16-Apr-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	SHAHRZAD HAMIDREZA FOROUGHI	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	08-Jan-2017 dd mm yy	Sex:	Female
784-2017-2182730-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	16/04/2025 dd mm yy	Symptom(s) as described by Patient:

Complaint

c/o: very less appetite

excessive hair fall

on exam: severe pallor, rachitic rosary, wrist widening

cns: intact

CVS:S1+S2+0

chest clear abdomen soft non tender.

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
16-Apr-2025	82306	Vitamin D; 25 hydroxy, includes fraction(s), if pe (Lab)	1	72.00
16-Apr-2025	83550	Iron binding capacity (Lab)	1	21.60
16-Apr-2025	82728	Ferritin (Lab)	1	33.30
16-Apr-2025	83540	Iron (Lab)	1	15.30
16-Apr-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
				157.50

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	16-Apr-2025	Dr Bushra	D50.9	Iron deficiency anemia, unspecified			Admitting Provider
Secondary	16-Apr-2025	Dr Bushra	E55.9	Vitamin D deficiency, unspecified			Admitting Provider
Secondary	16-Apr-2025	Dr Bushra	E55.0	Rickets, active			Admitting Provider

MEDICAL PLAN

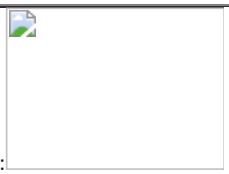
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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 Bushra		**Patient/Guardian signature**	
Tel/Fax: 0552397911			
Signature & Stamp:  			
Date: 16-04-2025		Date: 16-04-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			