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-May-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	ISHTIAQ AHMAD MEHTAB DIN	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	12-Sep-1992 dd mm yy	Sex:	Male
784-1992-2641417-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	19/05/2025 dd mm yy	Symptom(s) as described by Patient:

Complaint

flu

runny nose

at night nasal congestion

sneezing

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-May-2025	9	Consultation GP (General Consultation)	1	30.00
19-May-2025	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40
19-May-2025	0188-135906-2441	PULMICORT (Pharmacy)	1	10.48
19-May-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00
19-May-2025	0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 M (Pharmacy)	1	1.20
19-May-2025	86140	C-reactive protein; (Lab)	1	12.60
19-May-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
				92.98

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	19-May-2025	Dr.Farhan Iyas	J30.9	Allergic rhinitis, unspecified			Admitting Provider
Secondary	19-May-2025	Dr.Farhan Iyas	R09.81	Nasal congestion			Admitting Provider

MEDICAL PLAN

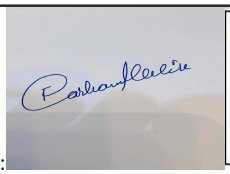
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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.Farhan Iyas		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp:  Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E			
Date: 19-05-2025		Date: 19-05-2025	

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