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:	24-May-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	ADNAN SAQIB MUHAMMAD ABDUL QADIR KHAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	12-Apr-1979 *dd mm yy*	**Sex:**	Male		
784-1979-5215815-8							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	24/05/2025 *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
24-May-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**9.00**
24-May-2025	11.01	Follow Up - Consultation Consultant **(General Consultation)**	1	**0.00**
24-May-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
24-May-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
24-May-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
24-May-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
				73.04

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	24-May-2025	DR Amaizah	R51.9	Headache, unspecified			Admitting Provider
Secondary	24-May-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider
Secondary	24-May-2025	DR Amaizah	G50.0	Trigeminal neuralgia			Admitting Provider
Secondary	24-May-2025	DR Amaizah	R68.84	Jaw pain			Admitting Provider
Secondary	24-May-2025	DR Amaizah	M62.9	Disorder of muscle, 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: Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E			
Date: 24-05-2025		Date: 24-05-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			