

AL MADALLAH Form



Claim Form

استمارة 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 Sex: Male

784-1979-5215815-8

INFORMATION

To be completed by Physician

Date of present symptoms: 24/05/2025 Symptom(s) as described by Patient:

dd mm yy

Pre-existing Condition(s) being treated for : ☐ No ☐ Yes

Chronic Medications: ☐ No ☐ Yes If Yes Specify

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

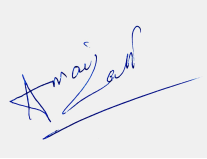
For Almadallah's Use only

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.			