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:	01-Jun-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	Liliia Timerova		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	12-Aug-1995 *dd mm yy*	**Sex:**	Female	
784-1995-1434721-2							
INFORMATION			***To be completed by Physician***				
Date of present symptoms:	01/06/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

P/C: sore throat

cough

runny nose

nasal congestion

headache

body ache

weakness

yellow sputum

low blood pressure

weakness

duration: since 2 days

o/e: hyperemia and chest congestion

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
01-Jun-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
01-Jun-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
01-Jun-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
01-Jun-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
01-Jun-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
				209.72

Date	CPT Code	Treatment	Qty	Unit Price
01-Jun-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
01-Jun-2025	0439-152905-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
01-Jun-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
01-Jun-2025	85004	Blood count; automated differential WBC count **(Lab)**	1	**12.60**
01-Jun-2025	0188-135906-2441	PULMICORT **(Pharmacy)**	1	**10.48**
				209.72

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	01-Jun-2025	Dr.Farhan Iyas	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	01-Jun-2025	Dr.Farhan Iyas	R05	Cough			Admitting Provider
Secondary	01-Jun-2025	Dr.Farhan Iyas	R09.81	Nasal congestion			Admitting Provider
Secondary	01-Jun-2025	Dr.Farhan Iyas	E86.0	Dehydration			Admitting Provider
Secondary	01-Jun-2025	Dr.Farhan Iyas	R52	Pain, unspecified			Admitting Provider
Secondary	01-Jun-2025	Dr.Farhan Iyas	R53.1	Weakness			Admitting Provider

MEDICAL PLAN

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

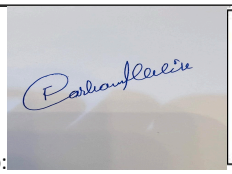
☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 01-06-2025		Date: 01-06-2025	

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