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:	07-Jun-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	SHYAM SUNDAR DAS BHARAT DAS	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	08-Jan-1973 *dd mm yy*	**Sex:**	Male		
784-1973-5834664-7							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	07/06/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

p/c: bilateral pain in feet.

patient is diabetic type 2 since 4 to 5 years

duration of pain:

since one month.

o/e there is swelling in big toe.

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
07-Jun-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
07-Jun-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
07-Jun-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
				45.50

Cause	☐ **Physical Illness**	☐ **Accident**	☐ **Maternity**	☐ **Preventive**	☐ **Psychiatric**	☐ **Dental**	☐ **Work Related**
☐ **Other(s)** Explain							
Assessment/ Diagnosis				☐ **Acute**	☐ **Chronic**	☐ **Confirmed**	☐ **Suspected**

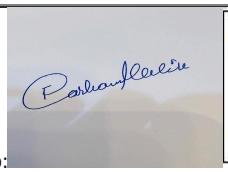
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	07-Jun-2025	Dr.Farhan Iyas	M25.572	Pain in left ankle and joints of left foot			Admitting Provider
Secondary	07-Jun-2025	Dr.Farhan Iyas	R52	Pain, unspecified			Admitting Provider

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.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: 07-06-2025	Date: 07-06-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.		