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:	12-Jun-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	Aryachandran Panayullakandypoyilil Karinthorammal	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	02-Oct-1997 *dd mm yy*	**Sex:**	Female
1751636					

INFORMATION

To be completed by Physician

Date of present symptoms:	12/06/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc : 1 episode of vomitting , burning pain and cramping pain causing severe discomfort started 10/06/25

ovarian cystectomy done previously

hx of gastritis previously

o/e : look irritable due to pain

tender epigastric region

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
12-Jun-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
12-Jun-2025	96374	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
12-Jun-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
12-Jun-2025	0005-136504-1021	SCOPINAL **(Pharmacy)**	1	**4.60**
12-Jun-2025	0005-174202-0781	RISEK 40MG **(Pharmacy)**	1	**34.00**
				88.40

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	12-Jun-2025	DR Amaizah	K29.00	Acute gastritis without bleeding			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	12-Jun-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider
Secondary	12-Jun-2025	DR Amaizah	R25.2	Cramp and spasm			Admitting Provider
Secondary	12-Jun-2025	DR Amaizah	R10.84	Generalized abdominal pain			Admitting Provider
Secondary	12-Jun-2025	DR Amaizah	R30.0	Dysuria			Admitting Provider
Secondary	12-Jun-2025	DR Amaizah	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed			Admitting Provider

MEDICAL PLAN

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

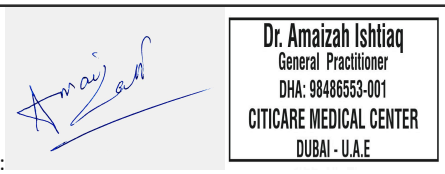
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 			
Date: 12-06-2025		Date: 12-06-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			