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-Jul-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	MOHAMED HAMDY MOHAMED KHODEIR	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	06-May-1986 dd mm yy	Sex:	Male
784-1986-5828590-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	01/07/2025 dd mm yy	Symptom(s) as described by Patient:

Complaint

follow up

crp is 12.5

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-Jul-2025	94640	Pressurized or nonpressurized inhalation treatment **(Co.Pay)**	1	**14.40**
01-Jul-2025	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR **(Pharmacy)**	1	**10.48**
01-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
01-Jul-2025	0195-107704-0802	CEFTRIAXONE SODIUM-Ceftriaxone-Tabuk **(Pharmacy)**	1	**48.50**
				120.18

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected

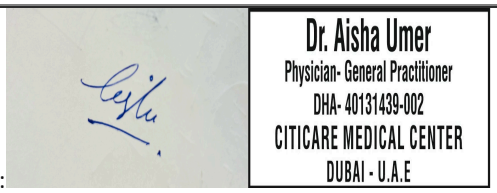
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	01-Jul-2025	AISHA	J39.0	Retropharyngeal and parapharyngeal abscess			Admitting Provider
Secondary	01-Jul-2025	AISHA	J45.991	Cough variant asthma			Admitting Provider

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: AISHA		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: 			
Date: 01-07-2025	Date: 01-07-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			