AL MADALLAH Form

almadallah
Healthcare Management

Claim Form

استمـــارة 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:	01-Jul-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	OMAR AHMED MAHMOUD ALI	◯ Mr. ◯ Mrs. ◯ Ms.			
Card #	Policy No.	Birth Date :	18-Nov-1981 *dd mm yy*	**Sex:**	Male
784-1981-8158649-0					

INFORMATION

To be completed by Physician

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

Complaint

chief complain: came with fever and cold, cough, sneezing, headache and body aches.

also throat pain

o/e: hyperemia and chest congestion

on investigation:

elevated CRP in blood

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	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
01-Jul-2025	9.01	Follow Up - Consultation GP **(General Consultation)**	1	**0.00**
01-Jul-2025	0439-152905-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
01-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
01-Jul-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
				132.70

Cause ☐ **Physical Illness** ☐ **Accident** ☐ **Maternity** ☐ **Preventive** ☐ **Psychiatric** ☐ **Dental** ☐ **Work Related**

☐ **Other(s)** Explain

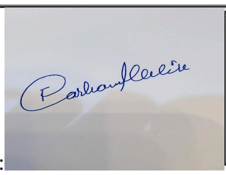
Assessment/ Diagnosis ☐ **Acute** ☐ **Chronic** ☐ **Confirmed** ☐ **Suspected**

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	01-Jul-2025	Dr.Farhan Iyas	R79.82	Elevated C-reactive protein (CRP)			Admitting Provider
Secondary	01-Jul-2025	Dr.Farhan Iyas	J06.9	Acute upper respiratory infection, 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: 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.			