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:	02-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	Sex:	Male		
784-1981-8158649-0			dd mm yy				
INFORMATION		*To be completed by Physician*					
Date of present symptoms:	02/07/2025 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
02-Jul-2025	9.01	Follow Up - Consultation GP (General Consultation)	1	0.00
02-Jul-2025	96360	Intravenous infusion, hydration; initial, 31 minut (Co.Pay)	1	32.40
02-Jul-2025	0439-152905-1001	LACTATED RINGERS INJECTION USP (Pharmacy)	1	5.00
02-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
02-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	02-Jul-2025	Dr.Farhan Iyas	R79.82	Elevated C-reactive protein (CRP)			Admitting Provider
Secondary	02-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

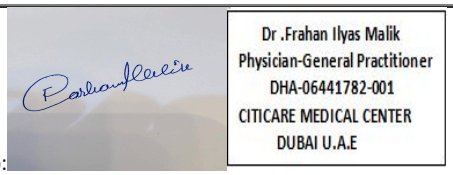
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: 			
Date: 02-07-2025	Date: 02-07-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			