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:	06-Jul-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	SAJID HUSSAIN MUHAMMAD SULEMAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	01-May-1986	Sex:	Male		
784-1986-8068354-1			dd mm yy				
INFORMATION		*To be completed by Physician*					
Date of present symptoms:	06/07/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

PC : FEVER THROAT PAIN

HOPC : PT CAME WITH THE COMPLAIN OF THROAT PAIN ALONG WITH FEVER BODY PAIN AND SNEEZING FOR ONE DAY

O/E THROAT IS HYPEREMIC

CHEST IS CLEAR

PMH : NONE

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
06-Jul-2025	9	Consultation GP (General Consultation)	1	30.00
06-Jul-2025	81000	Urinalysis, by dip stick or tablet reagent for bil (Lab)	1	5.40
06-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
06-Jul-2025	0439-152905-1001	LACTATED RINGERS INJECTION USP (Pharmacy)	1	5.00
06-Jul-2025	96360	Intravenous infusion, hydration; initial, 31 minut (Co.Pay)	1	32.40
06-Jul-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)	1	8.40
06-Jul-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	2	9.00
06-Jul-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 (Pharmacy)	1	2.34
06-Jul-2025	0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 M (Pharmacy)	1	1.20
06-Jul-2025	86140	C-reactive protein; (Lab)	1	12.60
06-Jul-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
				168.44

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	06-Jul-2025	AISHA	J03.90	Acute tonsillitis, unspecified			Admitting Provider
Secondary	06-Jul-2025	AISHA	R50.9	Fever, unspecified			Admitting Provider
Secondary	06-Jul-2025	AISHA	J30.89	Other allergic rhinitis			Admitting Provider
Secondary	06-Jul-2025	AISHA	E86.0	Dehydration			Admitting Provider
Secondary	06-Jul-2025	AISHA	R07.0	Pain in throat			Admitting Provider

MEDICAL PLAN

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

☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**

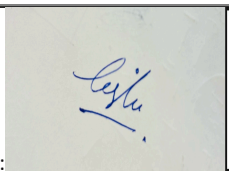
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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:  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E			
Date: 06-07-2025		Date: 06-07-2025	

Claims should be submitted with supporting documents within 30 days from date of service or as per contract.