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-Jul-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	ANAND SINGH DARWAN SINGH ANAND SINGH HARAKH SINGH NEGI		○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.		Birth Date :	01-Jun-1977 dd mm yy	Sex:	Male	
784-1977-8204854-6							
INFORMATION			*To be completed by Physician*				
Date of present symptoms:	12/07/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

PC epigastric pain,both sided chest pain not radiating to hand,shoulder or jaw

HOPC abdominal pain on and off since one week associated with vomiting at night

No dysuria\flank pain

H\o thyroidectomy 5 year back

known case of hypertension skipped the medicine today (name unknown)

No history of drug allergy

history of spicy food intake present

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-Jul-2025	9	Consultation GP (General Consultation)	1	30.00
12-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	46.80
12-Jul-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION (Pharmacy)	1	6.50
12-Jul-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	2	9.00
12-Jul-2025	93010	Electrocardiogram, routine ECG with at least 12 le (Co.Pay)	1	17.10
12-Jul-2025	86141	C-reactive protein; high sensitivity (hsCRP) (Lab)	1	24.30
12-Jul-2025	85027	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	12.60
12-Jul-2025	0005-136504-1021	SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJEC (Pharmacy)	1	4.60
12-Jul-2025	0005-174202-0781	RISEK 40MG (Pharmacy)	1	34.00
				184.90

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-Jul-2025	AISHA	R10.84	Generalized abdominal pain			Admitting Provider
Secondary	12-Jul-2025	AISHA	E86.0	Dehydration			Admitting Provider
Secondary	12-Jul-2025	AISHA	R11.2	Nausea with vomiting, unspecified			Admitting Provider
Secondary	12-Jul-2025	AISHA	I10	Essential (primary) hypertension			Admitting Provider
Secondary	12-Jul-2025	AISHA	R53.1	Weakness			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:

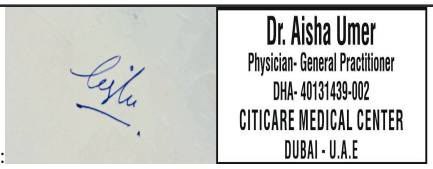
IN-PATIENT

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: 12-07-2025	Date: 12-07-2025

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