

AL MADALLAH Form



Claim Form

استمارة 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:	13-Jul-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	SHYAM SUNDAR DAS BHARAT DAS		☐ Mr. ☐ Mrs. ☐ Ms.			
Card #	Policy No.	Birth Date :	08-Jan-1973	Sex:	Male	
784-1973-5834664-7			dd mm yy			
INFORMATION						
To be completed by Physician						
Date of present symptoms:	13/07/2025	Symptom(s) as described by Patient:				
	dd mm yy					
Complaint						
Pt complaints of shivering following diabetic medicine intake HOPC Pt was under treatment for T2DM from india and 3 days back the medication was changed following which he feel the symptoms of hypoglycemia Known case of T2DM\HTN\DL P Advised to take T.Metformin 1000mg\glibenclamide 5mg 1\2-0-1\2 for one week and to recheck fbs and rbs on 21\7\25						
Pre-existing Condition(s) being treated for :		☐ No	☐ Yes			
Chronic Medications:		☐ No	☐ Yes	If Yes Specify		
Family History of any Illness		☐ No	☐ Yes			
OBJECTIVE/ASSESSMENT						
To be completed by Physician						
Clinical Finding						
Date	CPT Code	Treatment	Qty	Unit Price		
13-Jul-2025	9	Consultation GP (General Consultation)	1	30.00		
				30.00		
Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental
☐ Other(s) Explain						
Assessment/ Diagnosis			☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year
Primary	13-Jul-2025	KEERTHANA	E16.2	Hypoglycemia, unspecified		
Secondary	13-Jul-2025	KEERTHANA	E11.9	Type 2 diabetes mellitus without complications		
Secondary	13-Jul-2025	KEERTHANA	E78.01	Familial hypercholesterolemia		
Secondary	13-Jul-2025	KEERTHANA	E78.49	Other hyperlipidemia		
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: KEERTHANA		Patient/Guardian signature	
Tel/Fax:			
Signature & Stamp:  			
Date: 13-07-2025		Date: 13-07-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			