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:	14-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:	14/07/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

follow up

complain of difficulty to pass urine

lft is derange

adviced ultrasound abdomen

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
14-Jul-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
14-Jul-2025	81003	Urinalysis, by dip stick or tablet reagent for bil **(Lab)**	1	**3.60**
14-Jul-2025	76700	Ultrasound, abdominal, real time with image docume **(Radiology)**	1	**156.60**
				190.20

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
Secondary	14-Jul-2025	AISHA	K81.0	Acute cholecystitis			Admitting Provider
Secondary	14-Jul-2025	AISHA	R30.0	Dysuria			Admitting Provider
Secondary	14-Jul-2025	AISHA	E86.0	Dehydration			Admitting Provider
Primary	14-Jul-2025	AISHA	N39.0	Urinary tract infection, site not specified			Admitting Provider

MEDICAL PLAN

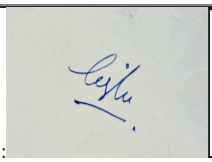
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: 14-07-2025		Date: 14-07-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			