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:	20-Jul-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	MUHAMMAD ADNAN FAZAL REHMAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	01-Jan-1988	**Sex:**	Male		
784-1987-0462425-7	IM237EA NLSB		*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	20/07/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint
pt came for neurobion injection

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
20-Jul-2025	9	Consultation GP (General Consultation)	1	30.00
				30.00

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	20-Jul-2025	AISHA	D51.8	Other vitamin B12 deficiency anemias			Admitting Provider
Secondary	20-Jul-2025	AISHA	E83.42	Hypomagnesemia			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:	

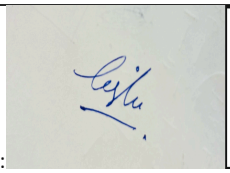
IN-PATIENT

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: 20-07-2025	Date: 20-07-2025
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.	