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:	30-Jul-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	NOMAN ILYAS MUHAMMAD ILYAS	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	28-Feb-1994	**Sex:**	Male
784-1994-4335332-3			*dd mm yy*		

INFORMATION

To be completed by Physician

Date of present symptoms:	30/07/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc :FEVER , COUGH , left foot burning

hopc : pt came with the complain FEVER , COUGH ,AND left foot burn with hot water

skin is red no boils

THROAT IS HYPEREMIC

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
25-Jul-2025	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
25-Jul-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**9.00**
25-Jul-2025	96361	Intravenous infusion, hydration; each additional h **(Co.Pay)**	1	**10.80**
25-Jul-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
25-Jul-2025	0384-111908-1001	SODIUM CHLORIDE B.P. **(Pharmacy)**	1	**4.50**
25-Jul-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
25-Jul-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
25-Jul-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
25-Jul-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
				129.14

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	30-Jul-2025	AISHA	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	30-Jul-2025	AISHA	R50.9	Fever, unspecified			Admitting Provider
Secondary	30-Jul-2025	AISHA	R07.0	Pain in throat			Admitting Provider
Secondary	30-Jul-2025	AISHA	E86.0	Dehydration			Admitting Provider
Secondary	30-Jul-2025	AISHA	R05	Cough			Admitting Provider
Secondary	30-Jul-2025	AISHA	T25.122A	Burn of first degree of left foot, initial encounter			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: 30-07-2025	Date: 30-07-2025

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