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:	25-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:	25/07/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

pc : left foot burning

hopc : pt came with the complain of left foot burn with hot water

skin is red no boils

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	25-Jul-2025	AISHA	T25.022S	Burn of unspecified degree of left foot, sequela			Admitting Provider
Secondary	25-Jul-2025	AISHA	R50.9	Fever, unspecified			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	25-Jul-2025	AISHA	R07.0	Pain in throat			Admitting Provider
Secondary	25-Jul-2025	AISHA	E86.0	Dehydration			Admitting Provider

MEDICAL PLAN

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

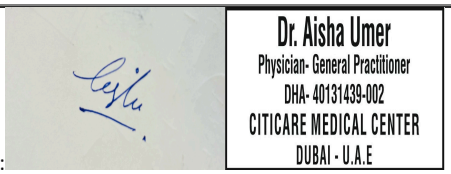
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: 25-07-2025		Date: 25-07-2025	

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