



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:	09-Aug-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC
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PATIENT INFORMATION

Patient's Name (as on card)	CHRISTIAN PERICLES WEDNESDAY AGUSTIN TIONGSON			☐ Mr. ☐ Mrs. ☐ Ms.		
Card #	Policy No.	Birth Date :	04-Apr-1979	Sex:	Male	
784-1979-4890248-7			dd mm yy			

INFORMATION

To be completed by Physician

Date of present symptoms:	09/08/2025	Symptom(s) as described by Patient:
	dd mm yy	

Complaint

Right upper quadrant pain radiating to the back x 3 days

General Examination:

Abdomen: Globular normoactive bowel sounds,tenderness on the right upper quadrant area

Pre-existing Condition(s) being treated for : Chronic Medications: Family History of any Illness	☐ No	☐ Yes	If Yes Specify
	☐ No	☐ Yes	
	☐ No	☐ Yes	

OBJECTIVE/ASSESSMENT

To be completed by Physician

Clinical Finding

Date	CPT Code	Treatment	Qty	Unit Price
09-Aug-2025	76700	Ultrasound, abdominal, real time with image docume (Radiology)	1	156.60
09-Aug-2025	9	Consultation GP (General Consultation)	1	30.00
				186.60

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
☐ Other(s) Explain							

Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	09-Aug-2025	KEERTHANA	K80.80	Other cholelithiasis without obstruction			Admitting Provider

MEDICAL PLAN

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

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy
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		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: 09-08-2025		Date: 09-08-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			