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

PATIENT INFORMATION

Patient's Name (as on card)	GABRIEL LAMBOT LAMPAS	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	27-Feb-1989 *dd mm yy*	**Sex:**	Male
784-1989-8465903-1					

INFORMATION

To be completed by Physician

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

Complaint

Severe abdominal pain,fever,right upper quadrant pain radiating to the right shoulder x 2 days.

General Examination:

Abdomen: Tenderness on the right upper quadrant area,globular normoactive bowel sounds

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
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

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	09-Aug-2025	KEERTHANA	K81.9	Cholecystitis, unspecified			Admitting Provider
Secondary	09-Aug-2025	KEERTHANA	R50.9	Fever, unspecified			Admitting Provider

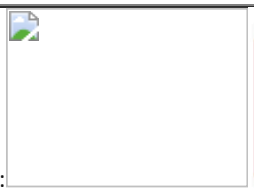
MEDICAL PLAN

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: 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.		