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:	10-Aug-2025	Healthcare Provider:	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)		VISHNURAJ ESWARAMANGALATH RAMESH RAMESH	○ Mr. ○ Mrs. ○ Ms.				
Card #		Policy No.	Birth Date :	02-Aug-2000 dd mm yy	Sex:	Male	
784-2000-3571192-6							
INFORMATION			To be completed by Physician				
Date of present symptoms:	10/08/2025 dd mm yy	Symptom(s) as described by Patient:					

Complaint

PC shortness of breath,cough with mucus,fever,bodypain,headache

HOPC pt presents with complaints of shortness of breath,cough with mucus,fever,bodypain,headache since 2 days

He is known asthmatic on MDI

o\e Chest bilateral wheeze present

SpO2 96 %

No history of drug allergy

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
10-Aug-2025	94640	Pressurized or nonpressurized inhalation treatment (Co.Pay)	1	14.40
10-Aug-2025	96374	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	10.80
10-Aug-2025	96372	Therapeutic, prophylactic, or diagnostic injection (Co.Pay)	1	9.00
10-Aug-2025	9	Consultation GP (General Consultation)	1	30.00
10-Aug-2025	86140	C-reactive protein; (Lab)	1	12.60
10-Aug-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, (Lab)	1	15.30
10-Aug-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S (Pharmacy)	1	8.40
10-Aug-2025	0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR (Pharmacy)	1	10.48
10-Aug-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 (Pharmacy)	1	2.34
				113.32

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	10-Aug-2025	KEERTHANA	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	10-Aug-2025	KEERTHANA	R05	Cough			Admitting Provider
Secondary	10-Aug-2025	KEERTHANA	R06.03	Acute respiratory distress			Admitting Provider
Secondary	10-Aug-2025	KEERTHANA	R50.9	Fever, unspecified			Admitting Provider
Secondary	10-Aug-2025	KEERTHANA	R51.9	Headache, unspecified			Admitting Provider
Secondary	10-Aug-2025	KEERTHANA	K29.00	Acute gastritis without bleeding			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:

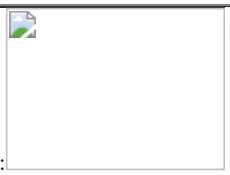
IN-PATIENT

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: 

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

Date: 10-08-2025	Date: 10-08-2025

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