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:	11-Aug-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC

PATIENT INFORMATION

Patient's Name (as on card)	AMIR JAWED ABBASI JAWED MUMTAZ ABBASI	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	04-Feb-1988 *dd mm yy*	**Sex:**	Unknown
784-1988-5909528-7					

INFORMATION

To be completed by Physician

Date of present symptoms:	11/08/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

pc : watery diarrhea ,vomiting ,stomach pain

hopc : pt came with the complain of stomach pain with vomiting and watery diarrhea started with mild fever started yesterday night

o/e she look dehydrated and dizzy having low blood pressure

allergies : none

pmh : none

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
11-Aug-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
11-Aug-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
11-Aug-2025	0439-152905-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	1	**5.00**
11-Aug-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	2	**9.00**
11-Aug-2025	0005-150403-1021	PREMOSAN **(Pharmacy)**	1	**0.90**
11-Aug-2025	0005-136504-1021	SCOPINAL **(Pharmacy)**	1	**4.60**
11-Aug-2025	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**22.50**
11-Aug-2025	0195-107704-0801	CEFTRIAXONE-TABUK IV **(Pharmacy)**	1	**48.50**
11-Aug-2025	96374	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
11-Aug-2025	0135-116604-1171	METRONIDAZOLE-Nidazole **(Pharmacy)**	1	**14.00**
11-Aug-2025	96365	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**46.80**
11-Aug-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
				260.80

Date	CPT Code	Treatment	Qty	Unit Price
11-Aug-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
11-Aug-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				260.80

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	11-Aug-2025	AISHA	R10.0	Acute abdomen			Admitting Provider
Secondary	11-Aug-2025	AISHA	R11.0	Nausea			Admitting Provider
Secondary	11-Aug-2025	AISHA	R11.12	Projectile vomiting			Admitting Provider
Secondary	11-Aug-2025	AISHA	R10.84	Generalized abdominal pain			Admitting Provider
Secondary	11-Aug-2025	AISHA	R19.7	Diarrhea, unspecified			Admitting Provider
Secondary	11-Aug-2025	AISHA	E86.0	Dehydration			Admitting Provider
Secondary	11-Aug-2025	AISHA	R50.81	Fever presenting with conditions classified elsewhere			Admitting Provider

MEDICAL PLAN

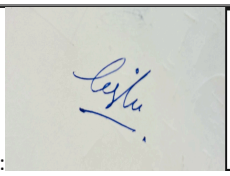
Itemized Original Invoices & Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ **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: 11-08-2025		Date: 11-08-2025	
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			