



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:	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	Sex:	Unknown
784-1988-5909528-7			dd mm yy		
INFORMATION					
To be completed by Physician					
Date of present symptoms:	11/08/2025	Symptom(s) as described by Patient:			
	dd mm yy				
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	96366	Intravenous infusion, for therapy, prophylaxis, or (Co.Pay)	1	14.40	
11-Aug-2025	0005-174202-0781	RISEK 40MG (Pharmacy)	1	34.00	
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	
				309.20	

Date	CPT Code	Treatment	Qty	Unit Price
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
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
				309.20

Cause	☐ Physical Illness	☐ Accident	☐ Maternity	☐ Preventive	☐ Psychiatric	☐ Dental	☐ Work Related
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☐ Other(s) Explain	
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Assessment/ Diagnosis	☐ Acute	☐ Chronic	☐ Confirmed	☐ Suspected
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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
Secondary	11-Aug-2025	AISHA	A05.9	Bacterial foodborne intoxication, unspecified			Admitting Provider
Secondary	11-Aug-2025	AISHA	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: AISHA	Patient/Guardian signature
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Tel/Fax:

Signature & Stamp:	Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E
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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.