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:	22-Aug-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	SHARON NAKIBUULE	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	10-Mar-1993	**Sex:**	Female		
784-1993-8705393-9			*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	22/08/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

pc : fever , body pain , runny nose

hopc : pt came with the complain of fever , runny nose started yesterday

o/e she look dehydrated and lethargic

allergies 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
22-Aug-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
22-Aug-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
22-Aug-2025	0384-111908-1001	SODIUM CHLORIDE B.P. **(Pharmacy)**	1	**4.50**
22-Aug-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	3	**9.00**
22-Aug-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
22-Aug-2025	0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE **(Pharmacy)**	1	**2.34**
22-Aug-2025	0005-111805-1021	CHLOROHISTOL 10MG **(Pharmacy)**	1	**1.20**
22-Aug-2025	96375	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**10.80**
22-Aug-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
22-Aug-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
22-Aug-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				133.04

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	22-Aug-2025	AISHA	J06.9	Acute upper respiratory infection, unspecified			Admitting Provider
Secondary	22-Aug-2025	AISHA	R50.9	Fever, unspecified			Admitting Provider
Secondary	22-Aug-2025	AISHA	J30.89	Other allergic rhinitis			Admitting Provider
Secondary	22-Aug-2025	AISHA	R05	Cough			Admitting Provider
Secondary	22-Aug-2025	AISHA	R07.0	Pain in throat			Admitting Provider
Secondary	22-Aug-2025	AISHA	E86.0	Dehydration			Admitting Provider

MEDICAL PLAN

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

☐ Consultation	☐ Physiotherapy	☐ Laboratory	☐ Radiology/Other	☐ Pharmacy

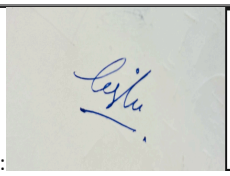
		For Almadallah's Use only
Pre-authorization Required for:		As per agreed tariff
Full details of proposed treatment/Surgery/Medicine:		Approval Code:

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: 			
Date: 22-08-2025		Date: 22-08-2025	

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