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

PATIENT INFORMATION

Patient's Name (as on card)	BHAGIKHAO MAHATO	○ Mr. ○ Mrs. ○ Ms.			
Card #	Policy No.	Birth Date :	01-Jan-1985 *dd mm yy*	**Sex:**	Male
784-1984-6248753-3					

INFORMATION

To be completed by Physician

Date of present symptoms:	23/08/2025 *dd mm yy*	Symptom(s) as described by Patient:

Complaint

chief complain:

previous history of hyperlipidemia, high triglycerides.

last report was one on 17/05/25

came to do reports again to check if its normal after treatment.

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
23-Aug-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
23-Aug-2025	80061	Lipid panel This panel must include the following: **(Lab)**	1	**44.10**
				74.10

Cause	☐ **Physical Illness**	☐ **Accident**	☐ **Maternity**	☐ **Preventive**	☐ **Psychiatric**	☐ **Dental**	☐ **Work Related**
☐ **Other(s)** Explain							

Assessment/ Diagnosis	☐ **Acute**	☐ **Chronic**	☐ **Confirmed**	☐ **Suspected**

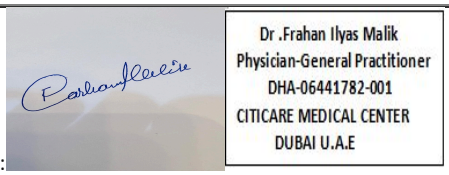
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	23-Aug-2025	Dr.Farhan Iyas	I10	Essential (primary) hypertension			Admitting Provider
Secondary	23-Aug-2025	Dr.Farhan Iyas	E78.5	Hyperlipidemia, unspecified			Admitting Provider
Secondary	23-Aug-2025	Dr.Farhan Iyas	E78.1	Pure hyperglyceridemia			Admitting Provider
Secondary	23-Aug-2025	Dr.Farhan Iyas	R60.0	Localized edema			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: Dr.Farhan Iyas		**Patient/Guardian signature**	
Tel/Fax:			
Signature & Stamp: 			
Date: 23-08-2025	Date: 23-08-2025		
Claims should be submitted with supporting documents within 30 days from date of service or as per contract.			