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)	BINNY MADAAN	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	10-Jan-1987	**Sex:**	Male		
784-1987-4063400-5			*dd mm yy*				
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	23/08/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

PC :HEADACHE UNI ALTERAL SEVRE LOW BACK PAIN ASSOCIATED IWTH DIFFICULTY IN STANDING AND BENDING AND PAIN IN NECK ASSOCIATED WITH STIFFNESS AND RESTRICTYED MOVEMANT ON RIGHT SIDE

O/E : TENDER LOW BACK AND SPINE

TENDER AND STIFFNESS

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	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
23-Aug-2025	0005-149902-1021	CLOFEN **(Pharmacy)**	1	**6.50**
				15.50

Cause	☐ **Physical Illness**	☐ **Accident**	☐ **Maternity**	☐ **Preventive**	☐ **Psychiatric**	☐ **Dental**	☐ **Work Related**
☐ **Other(s)** Explain							
Assessment/ Diagnosis				☐ **Acute**	☐ **Chronic**	☐ **Confirmed**	☐ **Suspected**

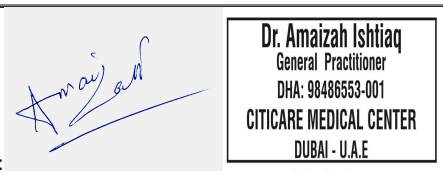
Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Primary	23-Aug-2025	DR Amaizah	M54.5	Low back pain			Admitting Provider
Secondary	23-Aug-2025	DR Amaizah	R51.9	Headache, unspecified			Admitting Provider
Secondary	23-Aug-2025	DR Amaizah	M62.830	Muscle spasm of back			Admitting Provider

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 Amaizah		**Patient/Guardian signature**	
Tel/Fax: 0561012068			
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.			