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:	20-Feb-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC				
PATIENT INFORMATION							
Patient's Name (as on card)	AKSHAYA KUMAR ADKA CHANDRASHEKAR	○ Mr. ○ Mrs. ○ Ms.					
Card #	Policy No.	Birth Date :	20-Feb-1995 *dd mm yy*	**Sex:**	Male		
784-1995-6365268-6							
INFORMATION		***To be completed by Physician***					
Date of present symptoms:	20/02/2025 *dd mm yy*	Symptom(s) as described by Patient:					

Complaint

patient came with the complaIN OF fever runny nose throat pain and body paIN For one day

chest is clear

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
20-Feb-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
20-Feb-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
20-Feb-2025	96367	Intravenous infusion, for therapy, prophylaxis, or **(Co.Pay)**	1	**22.50**
20-Feb-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
20-Feb-2025	2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) S **(Pharmacy)**	1	**8.40**
20-Feb-2025	82947	Glucose; quantitative, blood (except reagent strip **(Lab)**	1	**6.30**
20-Feb-2025	80061	Lipid panel This panel must include the following: **(Lab)**	1	**44.10**
20-Feb-2025	86140	C-reactive protein; **(Lab)**	1	**12.60**
20-Feb-2025	85025	Blood count; complete (CBC), automated (Hgb, Hct, **(Lab)**	1	**15.30**
				154.70

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	20-Feb-2025	Humaira	J02.9	Acute pharyngitis, unspecified			Admitting Provider
Secondary	20-Feb-2025	Humaira	R50.9	Fever, unspecified			Admitting Provider
Secondary	20-Feb-2025	Humaira	I10	Essential (primary) hypertension			Admitting Provider

Type	Date	Doctor	ICD Code	Diagnosis	Notes	year	Problem Role
Secondary	20-Feb-2025	Humaira	E78.5	Hyperlipidemia, unspecified			Admitting Provider
Secondary	20-Feb-2025	Humaira	R05	Cough			Admitting Provider
Secondary	20-Feb-2025	Humaira	R73.9	Hyperglycemia, unspecified			Admitting Provider
Secondary	20-Feb-2025	Humaira	J30.9	Allergic rhinitis, unspecified			Admitting Provider

MEDICAL PLAN

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

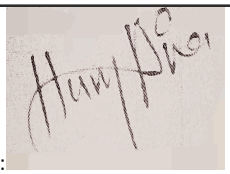
☐ **Consultation**	☐ **Physiotherapy**	☐ **Laboratory**	☐ **Radiology/Other**	☐ **Pharmacy**
			For Almadallah's Use only	
Pre-authorization Required for:			As per agreed tariff	
Full details of proposed treatment/Surgery/Medicine:			Approval Code:	

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: Humaira		**Patient/Guardian signature**	
Tel/Fax: 0524244416			
Signature & Stamp:  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.			
Date: 20-02-2025		Date: 20-02-2025	

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