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:	18-Mar-2025	**Healthcare Provider:**	CITICARE MEDICAL CENTER LLC			
PATIENT INFORMATION						
Patient's Name (as on card)	ANOOP PARAPPARAMBIL ASOKAN PARAPPARAMBIL KARUNAN RUDRAN ASOKAN	○ Mr. ○ Mrs. ○ Ms.				
Card #	Policy No.	Birth Date :	23-May-1987	**Sex:**	Male	
784-1987-3865171-4			*dd mm yy*			
INFORMATION		***To be completed by Physician***				
Date of present symptoms:	18/03/2025 *dd mm yy*	Symptom(s) as described by Patient:				

Complaint

pc : hx of injury with kitchen knife while he was sharpening knife on 18/03/25

presented with perfuse bleeding from wound and severe pain which is 7 on pain scale started 18/03/25

associated with feeling dizzy with cold and low blood pressure 18/03/25

o/e :

look plae ,

week pulse , cold periphery

low blood pressure 90/60 mmhg

3*3 cm lacerated wound on left hand medial half involving little finger without foreign body with perfuse bleeding on

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
18-Mar-2025	9	Consultation GP **(General Consultation)**	1	**30.00**
18-Mar-2025	96361	Intravenous infusion, hydration; each additional h **(Co.Pay)**	1	**10.80**
18-Mar-2025	96360	Intravenous infusion, hydration; initial, 31 minut **(Co.Pay)**	1	**32.40**
18-Mar-2025	0102-152902-1001	LACTATED RINGERS INJECTION USP **(Pharmacy)**	2	**5.00**
18-Mar-2025	96372	Therapeutic, prophylactic, or diagnostic injection **(Co.Pay)**	1	**9.00**
18-Mar-2025	0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION **(Pharmacy)**	1	**6.50**
18-Mar-2025	12042	Repair, intermediate, wounds of neck, hands, feet **(Co.Pay)**	1	**510.30**
				604.00

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	18-Mar-2025	DR Amaizah	S61.218S	Laceration w/o fb of finger w/o damage to nail, sequela			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	S61.412A	Laceration without foreign body of left hand, init encntr			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	R52	Pain, unspecified			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	L03.90	Cellulitis, unspecified			Admitting Provider
Secondary	18-Mar-2025	DR Amaizah	R03.1	Nonspecific low blood-pressure reading			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:

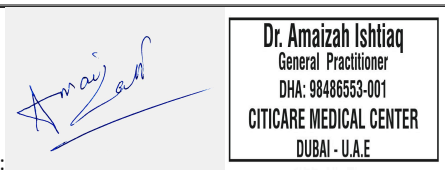
IN-PATIENT

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:  Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	
Date: 18-03-2025	Date: 18-03-2025

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