eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out Patient** at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	**CAROLINA JAPA**	Gender:	**Female**	Validity Between:	**01/09/2024 and 31/08/2025**
Card No:	**E64D-F765-50C5-58E5**	DOB:	**12/12/1971 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1971-8624032-7**	Service Date:	**12-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502209194**		
Policy Holder:		Threshold Limit:			
Payer Name:	**AL WATHBA NATIONAL INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42526**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):	**Date of Symptoms/illness started**		
Complaint	DD	MM	YYYY
PC: HYPERLIPIDEMIC HYPERTENSION P[REVIOUSLY KNOWNSTOMACH PAIN LOW BACK PAIN BRONCHITIS GOUT KNOWN CASE			

Past Medical Surgical History?	○ Yes	○ No	**Date of Symptoms/illness started**		
			DD	MM	YYYY

Obs/Gyn Claims						**Date of Symptoms/illness started**		
						DD	MM	YYYY
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:			

What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy

Is the Patient under any type of Treatment? ○ Yes ○ No if yes, indicate what Assessment and since when:

OBJECTIVE / ASSESSMENT ***(To be completed by Physician)***

Clinical Findings :	Vital Signs : B/P : 114 T : 36.6 HR : 76 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	E78.5	Hyperlipidemia, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
Secondary	M54.5	Low back pain

Type	Code	Diagnosis
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	M1A.9XX0	Chronic gout, unspecified, without tophus (tophi)

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

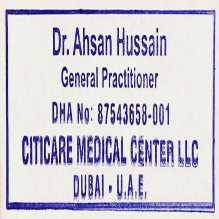
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
84550	Uric acid; blood	Lab	15.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000

Code	Generic	Duration	Instructions
0071-155103-1171	(AMLODIPINE : 5 MG) (PERINDOPRIL : 5 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0003-375703-0391	(FEBUXOSTAT : 80 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0027-344907-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) before meal
0090-122303-0392	(ETORICOXIB : 90 MG) FILM COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0110-116501-1451	(AMPICILLIN : 250 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

◯ Pharmacy:	Estmated Costs	◯ Laboratory / Radiology:	Estmated Costs
Is the following required	◯ Surgery:	◯ Endoscopy:	
	◯ Physiotherapy:	◯ Other Procedures:	
		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **AHSAN HUSSAIN**		
Tel / Fax (important):		

Signature & Stamp



Patient's Signature(Parent if minor)

Date :	Date : 12-Sep-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	