eASOAP FORM

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

Patent Name:	**Shazad Ahmed Mohammad Razaq**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**0858-6A31-8C77-7E12**	DOB:	**4/15/1983 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1983-8368464-8**	Service Date:	**17-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0552914624**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44195**	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: HYPERTENSION KNOWN ASTHMATIC KNOWN CAME TO REFILL MEDICATION LOW BACK PIAN STOMACH PAIN			

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 : 116 T : 37 HR : 108 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I10	Essential (primary) hypertension
Secondary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	R73.9	Hyperglycemia, unspecified
Secondary	M54.5	Low back pain
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

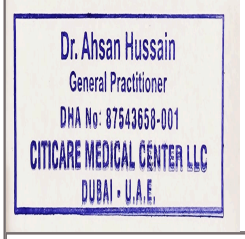
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9	Consultation GP	General Consultation	60.0000
86677	Antibody; Helicobacter pylori	Lab	75.6000

Code	Generic	Duration	Instructions
0027-149903-0111	(DICLOFENAC SODIUM : 100 MG) COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0027-179203-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0281-367801-0431	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	30	Take 1Gel 2 Time(s) per Day For 30 Day(s) others
0186-143701-0061	(CELECOXIB : 200 MG) CAPSULES	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
1233-211702-0393	(ATORVASTATIN : 10 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	30	Take 1Powder 3 Time(s) per Day For 30 Day(s) others
1513-242802-1751	(PANTOPRAZOLE (AS SODIUM) : 40 MG) GASTRO-RESISTANT TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) before meal
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 2 Time(s) per Day For 30 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 : 17-Sep-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		