eASOAP FORM

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

Patent Name:	**ARUNA PRABATH THILAKARATHNA SINGH RATHNA**	Gender:	**Male**	Validity Between:	**22/07/2024 and 21/07/2025**
Card No:	**F88C-8902-532E-17B6**	DOB:	**12/29/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-6293586-8**	Service Date:	**28-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0529642078**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44342**	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: DIABETIC KNOWN CAME TO REFILL MEDICATION			

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 : 138	T : 36.4	HR : 87	RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	E11.65	Type 2 diabetes mellitus with hyperglycemia
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	I10	Essential (primary) hypertension

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

Code	Generic	Duration	Instructions
0188-155602-0391	(ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
1504-575601-3621	(ASCORBIC ACID (VITAMIN C) : 120 MG) (VITAMIN D : 400 IU) (VITAMIN E : 30 IU) (THIAMINE (VITAMIN B1) : 1.8 MG) (RIBOFLAVINE (VITAMIN B2) : 1.7 MG) (NIACIN (VITAMIN B3; NICOTINIC ACID) : 20 MG) (PYRIDOXINE (VITAMIN B6) : 2.6 MG) (FOLIC ACID : 800 MCG) (VITAMIN B12 : 8 MCG) (IRON (AS FERROUS FUMARATE) : 28 MG) (ZINC : 25 MG) (DHA (DOCOSAHEXAENOIC ACID) : 200 MG) TABLET + SOFTGEL	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
5098-164203-2001	GLICLAZIDE	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
1400-204901-0361	(METFORMIN HCL : 1000 MG) (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) EXTENDED RELEASE TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal

○ 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 Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 28-Sep-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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