

eASOAP FORM

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

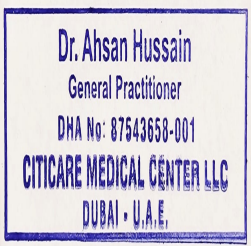
Patent Name:	MOHAMMED ABUL FAZAL HAJEE ALI AHMED	Gender:	Male	Validity Between:	07/12/2023 and (
Card No:	0E78-7BD6-2B00-B91A	DOB:	5/17/1965 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans: MEDGULF
Natonal ID:	784-1965-9596925-2	Service Date:	19-Oct-2024	Radiology:	Covered
		Patent's Tel No:	0558743379		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	36862	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 Symptom	
Complaint						DD	MM
For routine medications.							
Known hypertensive, hypercholesterolemia, diabetic and benign hypertrophic hypertrophy							
Also complaint of severe itching rash on the right leg							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						DD	MM
☐ 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 : 110 T : 36.9 HR : RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	L30.9	Dermatitis, unspecified	
Secondary	I10	Essential (primary) hypertension	
Secondary	E78.2	Mixed hyperlipidemia	
Secondary	Z79.899	Other long term (current) drug therapy	
Secondary	H01.119	Allergic dermatitis of unspecified eye, unspecified eyelid	
Secondary	J20.9	Acute bronchitis, unspecified	
Secondary	N39.0	Urinary tract infection, site not specified	
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/illne
☐ 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	
9	GP Consultation	General Consultatic	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	
Code	Generic	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	14	Take 1Syrup 2 Time(s) per Day F others
0085-252804-0371	(PROPYLENE GLYCOL : 0.6%/ML) EYE DROPS	14	Take 1Drops 2 Time(s) per Day F others
0137-242801-0342	(PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day before meal
0137-238401-0391	(TAMSULOSIN HCL : 0.4 MG) FILM COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day others
0696-148701-1171	(LORATADINE : 10 MG) TABLETS	20	Take 1Tablets 1 Time(s) per Day others
☐ Pharmacy:		Estimated Costs	
☐ Laboratory / Radiology:		Estimated Costs	
Is the following required		☐ Surgery:	☐ Endoscopy:
		☐ Physiotherapy:	☐ Other Procedures:
		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider
<i>I hereby certify 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>	<i>I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>
Treating Physician Name : AHSAN HUSSAIN	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 19-Oct-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE: no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.