eASOAP FORM

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

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 (Al Ansa 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 For routine medications. Known hypertensive, hypercholesterolemia, diabetic and benign hypertrophic hypertrophy Also complaint of severe itching rash on the right leg	DD	MM

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:	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
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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managemer 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 : 19-Oct-2024
Note: Claims must be submited along with supportng 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.