eASOAP FORM

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

Patent Name:	**FIRAS LAMARI**	Gender:	**Male**	Validity Between:	**26/07/2024 and 29/11/2024**
Card No:	**C430-FE18-58B3-0DFC**	DOB:	**5/26/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-7920865-5**	Service Date:	**07-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0585954898**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MetLife**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43731**	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**		
	DD	MM	YYYY
Complaint PC: Constipation, swelling in the anal verge. Duration: 1week Also has nasal congestion, runny nose and cough. Duration: 3days There is no fever. DRE: Declined.			

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 : 120	T : 36.8	HR : 78	RR : 18

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

Type	Code	Diagnosis
Primary	K64.1	Second degree hemorrhoids
Secondary	J06.9	Acute upper respiratory infection, unspecified

Type	Code	Diagnosis
Secondary	J30.9	Allergic rhinitis, unspecified

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
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0086-225101-2091	(POTASSIUM CHLORIDE : 46.6 MG) (POLYETHYLENE GLYCOL : 13.125 G) (SODIUM BICARBONATE : 178.5 MG) (SODIUM CHLORIDE : 350.7 MG) ORAL POWDER	10	Take 1Powder 2 Time(s) per Day For 10 Day(s) after meal
0071-158501-0391	(HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION) : 450 MG) FILM COATED TABLETS	15	Take 1Tablets 2Time(s) perDay For 15 Day(s) after meal
0016-119401-2231	(ZINC OXIDE : 296 MG) (BALSAM PERUVIAN SINE RESINA : 49 MG) (BISMUTH OXIDE : 24 MG) (BISMUTH SUBGALLATE : 59 MG) RECTAL SUPPOSITORIES	12	Take 1Tablets 1Time(s) perDay For 12 Day(s) evening
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
0005-119803-1171	(PREDNISOLONE : 20 MG TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 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 : **Enomen Goodluck**	
Tel / Fax (important):	

Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 07-Nov-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	