## **eASOAP FORM**



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

**INAYA EQUBAL MD** Patent Name: Gender: **Female** Validity Between: 06/08/2024 and 28/02/2025 **EQUBAL ASHRAF** 9/25/2022 12:00:00 Coverage Informaton Card No: 8890-BCBD-7BC4-8740 DOB: **Out Patient** ΑM for: RN UAE (Al Ansari-AUH)-Pin #: **Identty Card:** Network: **MEDGULF** Natonal ID: 784-2022-4880267-4 Service Date: 14-Dec-2024 Radiology: Covered Patent's Tel No: 0566960387 Threshold Policy Holder: Limit: Payer Name: **DP World** Class: Normal Out-Patent: Patent's File 44836 Category: **Category B** Pharmacy: Co-Part: 20% No: Gatekeeper: Consultation: Laboratory: Covered No Referral No: Referred Service: CLIDIFOTIVE ACCECCATAIN

Assessment/Diagnosis: Acute Chronic INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary K59.00 Constipation, 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?  O Yes O No	moss startet	Symptoms/	Date of				:	Complaint	atent (Chief	cribed by the	m(s) as o	Symptom(
Past Medical Surgical History?  Past Medical Surgical History.  Past Medical Surgical History.	YYYY	MM	DD		Complaint							
Past Medical Surgical History?  Obs/Gyn Claims  Date of Symptoms/i DD MM  Para Gravida: AB: LMP: Marital Status: Marital Date:  What date did the Patient first feel same / similar Symptom(s): dd mm yyyy  s 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:0 T:36 HR:10  : 24  Assessment/Diagnosis: Acute Chronic INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary K59.00 Constipation, unspecified  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/illness of the property of the property injury due to road accident?  Oyes No									24	2 days 12/12/2	nstipatio	pc: cons
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Para Gravida: AB: LMP: Marital Status: Marital Date:  What date did the Patient first feel same / similar Symptom(s): dd mm yyyy s the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when:  DBJECTIVE / ASSESSMENT(To be completed by Physician)  Clinical Findings: Vital Signs: B/P:0 T:36 HR:100:24  Assessment/Diagnosis: Acute Chronic INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary K59.00 Constipation, unspecified  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/illness accident? Describe how the accident or work related injury/illness	  IIness starte	 Symptoms,	Date of								Claims	Oha/Cun (
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	ork related injury/illness occur:			t or worl	to road Describe how the accident or v		Macadent or illness due to work?					
					Yes O No		○ Yes ○					
Date of accident or beginning of illness:									ness:	beginning of i	accident	Date of ac
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim		der claim	to consi	enclose	Results must be e	/ Reports / I	Prescriptions	Applicable	nvoices and	mized Original	L PLAN I	

CPT Code		Treatm	nent	Туре			Price
9		GP Cor	nsultation	General Consultation			25.0000
Code	Generic				Duration	Instructi	ons
6789- 955301-3411			/ 3G) (MALLOW FLUID EXTRACT : 0.1 G / 3 G) EXTRACT : 0.1 G / 3 G) ENEMA SOLUTION		2		lution 2 Time(s) per 2 Day(s) others
6881- 656201-0901	,		0 : 6.563 G (SODIUM HYDROGEN DE : 175.4 MG (POTASSIUM CHL		1/1		wder 1Time(s) perDay ay(s) others
O Pharmacy:			Estmated Costs	O Laboratory / Radiolog	gy: Estmated C		osts
Is the following required		O Surgery:	O Endoscopy:	○ Endoscopy:			
			O Physiotherapy:	Other Procedures:	Other Procedures:		
			If yes please specify	If yes please specify			

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, E	mployer or other Organizaton
& that the medical services shown on this form were	to release any informaton regarding my medical cond	diton and history to NEXtCARE
medically indicated & necessary for the management of	for the purpose of determining insurance benefts. Me	edical management is the sole
this case.	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 DUBAL - U.A.E.  Date:	Patient's Signature(Parent if minor)  Date: 14-Dec-2024	
Note: Claims must be submited along with supporting doci	uments within 30 days from date of service	

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