eASOAP FORM

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

Patent Name:	**BERNARD TANIOS AWAD**	Gender:	**Male**	Validity Between:	**15/07/2024 and 14/07/2025**
Card No:	**67D9-09E4-0CD3-25F8**	DOB:	**6/28/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1982-9818770-3**	Service Date:	**01-Jan-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0522582851**		
Policy Holder:		Threshold Limit:			
Payer Name:	**National Life And General Insurance**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45403**	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 :rt toe nail pain , for 5 days , fever 3 days bp is elevated o/e ; swelling of nail bed, redish discoloration of skin counselled for the need of partial resection of ingrowing nail he want to schedule it after a few days			

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 : 150 T : 36.7 HR : 88 RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	L03.031	Cellulitis of right toe
Secondary	A78	Q fever

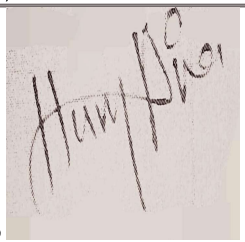
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000

Code	Generic	Duration	Instructions
2594-627701-1171	(VITAMIN D3 : 400 IU) (MAGNESIUM : 48 MG) (ZINC : 3.4 MG) (VITAMIN K2 : 90 MCG) (CALCIUM : 320 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
2608-101701-0391	(ACECLOFENAC : 100 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
1394-143701-1453	(CELECOXIB : 200 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0005-128203-1171	(SULFAMETHOXAZOLE : 800 MG) (TRIMETHOPRIM : 160 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 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 : **Humaira**		
Tel / Fax (important):		
Signature & Stamp  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 01-Jan-2025	

Note: Claims must be submited along with supportng documents within 30 days from date of service

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