

eASOAP FORM

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

Patent Name:	MELDREN LATIBAN COTIC	Gender:	Female	Validity Between:	25/10/2024 and 08/02/2025
Card No:	E085-94F3-EB64-4568	DOB:	6/25/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-6781182-9	Service Date:	15-Jan-2025	Radiology:	Covered
		Patent's Tel No:	971526519393		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45544	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
co pusy nodules in axilla in both sides 9th n jan. 2025 Imp 9th jan . 2025	
oe pus is coming in both sides lymph nodes are also enlarged	
chest is clear no added sounds	

Complaint								
restless								
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 : 136 T : 36.5 HR : 57 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Primary	L02.411	Cutaneous abscess of right axilla						
Secondary	R50.9	Fever, unspecified						
Secondary	R52	Pain, 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	
9	GP Consultation					General	25.0000	

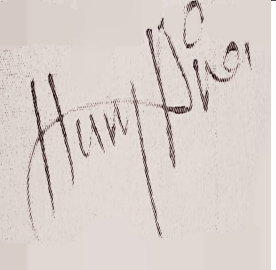
CPT Code	Treatment	Type	Price
		Consultation	
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000

Code	Generic	Duration	Instructions
0005-107001-0051	(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 Day(s) others
0195-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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>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 other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Humaira		
Tel / Fax (important):		

 <i>Signature & Stamp</i> Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 15-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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