ADMINISTRATIVE

eASOAP FORM



The member is allowed for **Out Patient**

at the CITICARE MEDICAL CENTER LLC

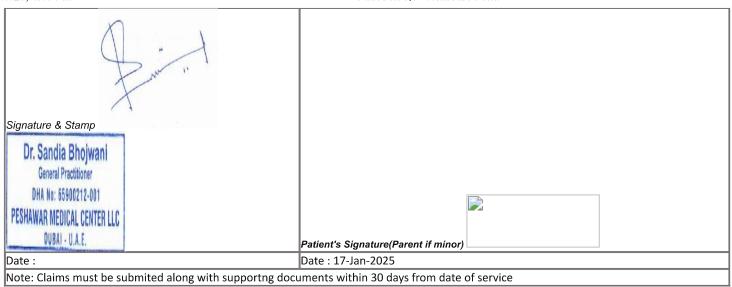
Patent Name:	SUSEEMA SAJEEWANI	Gender:	Female	Validity Between:	11/06/2024 and 10/06/2025
Card No:	1223-F863-C636-5B34	DOB:	2/9/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1978-0264273-2	Service Date:	17-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0521050940		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	36230	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								YYYY	
PC: LOWE	R BACK PAIN , HX OF	HEAVY OBJE	CT LIFTIN	G					
BP IS RAISED) NOT TAKING								
						Date o	Date of Symptoms/illness started		
Past Medical Surgical History?			○Yes	○ No	DD	MM	YYYY		
I()hs/(¬vn (Taims							Date of Symptoms/illness started		
						DD	MM	YYYY	
☐ Para	Gravida:	□ АВ:	LMP:	Marital Status:	Marital Date:	\dashv			
What date did	the Patient first feel sa	me / similar S	ymptom(s)	: dd mm yyyy					
I s the Patient ເ	nder any type of Treat	ment? O Ye	s O No	if yes, indicate what	Assessment and since wh	nen:			

OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :						Vital Signs: B/P:120 T:36:18			HR : 85 RR			
Assessment/Dia	gnosis CATE D	: O Acu IAGNOSIS N		Chronic TOM	O Confirmed	d OSuspecte	ed					
Туре	Code Diagnosis											
Primary R03.0 E				evated bloo	d-pressure rea	ding, w/o diagn	osis of htn					
Secondary M25.50 P				Pain in unspecified joint								
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)												
				Injury due accident?	to road	Describe how the accident or work related injury/illness occur:					cur:	
○ Yes ○ No				○ Yes ○) No							
Date of accident												
MEDICAL PLAN I	temize	d Original Inv	oices and	l Applicable	Prescriptions /	Reports / Resu	lts must be e	nclosed	to consider o	claim		
CPT Code	Treatr	ment							Туре		Price	
9	GP Consultation General Consultation 25								25.0000			
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478) 45.0									45.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular								10.0000			
0005- 149902- 1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION								Pharm	пасу	6.5000	
Code	Gei	neric					Duration	Instruc	tions			
2093-596002- 0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL						7		ke 1Tablets 1 Time(s) per Day For 7 ny(s) others			
0186-143701- 0061	(CE	LECOXIB : 20	00 MG CA	PSULES			7		ake 1Tablets 2 Time(s) per Day For 7 pay(s) others			
2150-575201- 1171		LCIUM : 400 NC : 4 MG TA		AMIN D3 : 20	00 IU (MAGNE:	SIUM : 100 MG	30		Take 1Tablets 1 Time(s) per Day For 30 Day(s) others			
1217-373201- 2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS					7 Take 1Tablets 1 Time(s) per Da Day(s) others				ay For 7		
O Pharmacy: Estmated				Costs		O Laboratory / Radiology: Estr			Estmated Costs			
			O Surge	gery:		O Endoscopy:						
			O Physic	otherapy:		Other Procedures:						
						If yes please specify						
Is In-patient Requ	ıired ? L	ength of Stay	<i>'</i>			Indicate Provide	er			Estima	ate Cost	
I hereby certfy t	hat all i	nformaton n	nentoned			orize any Health					-	
& that the medion medically indical this case.			-		for the purpo	y informaton reg se of determinir of doctor and t	ng insurance			-		
Treating Physicia	n Name	: SANDIA			,	-,	,					
Tel / Fax (important):												



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