## **eASOAP FORM**



**ADMINISTRATIVE** The member is allowed for Out Patient at the CITICARE MEDICAL CENTER LLC MOHAMMED RAASHID Patent Name: **MEERAN MOHIDEEN** Gender: Male Validity Between: 03/08/2024 and 02/08/2025 **MEERAN MOHIDEEN** Coverage Informaton 7/20/1995 12:00:00 16EC-7DD8-09A9-AB29 Card No: DOB: **Out Patient** AM for: RN UAE (Al Ansari-AUH)-Pin #: **Identty Card:** Network: **MEDGULF** Natonal ID: 784-1995-5715357-6 Service Date: 31-Jan-2025 Radiology: Covered Patent's Tel No: 0562857484 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File 45708 **Category B** Pharmacy: Co-Part: 20% Category: No: Gatekeeper: Consultation: Laboratory: Covered No Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started DD MM YYYY Complaint co accidently fell down on the road cut on the forehead bleed yesterday night 30th jan. 2025 oe 8cm laceration onthleft side of the forehead stitches needed chest is clear no added sounds restless Date of Symptoms/illness started ○ Yes O No Past Medical Surgical History? DD YYYY MM Date of Symptoms/illness started Obs/Gyn Claims DD YYYY MM ☐ 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?  $\bigcirc$  Yes  $\bigcirc$  No if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:140 T:36.8 HR: 110 RR : 18 O Acute O Chronic O Confirmed Suspected Assessment/Diagnosis: INDICATE DIAGNOSIS NOT SYMPTOM

Туре	Code	Diagnosis
Primary	S01.81XA	Laceration w/o foreign body of oth part of head, init encntr
Secondary	R50.9	Fever, unspecified
Secondary	L08.9	Local infection of the skin and subcutaneous tissue, unsp

ACCIDENT/0	OCCUPATIONA	AL Claim Ir	nformaton	(complete i	f claim is a re	sult of accident or work	related illne	ess/injury)		
Accident or illness due to work? Injury due accident?				to road	Describe how the accident or work related injury/illness occur:					
○ Yes ○ No ○ Yes ○				No						
Date of accident or beginning of illness:										
MEDICAL PL	AN Itemized (	Original In	voices and .	Applicable F	rescriptions /	<sup>'</sup> Reports / Results must l	oe enclosed	to consider clai	m	
CPT Code	Treatment							Туре		Price
12013	Simple repai membranes;		Co.Pay		100.0000					
9	GP Consulta		General Consultation		25.0000					
	ı				1					
Code Generic				Duration		ns				
No Prescrip	tions History	Found								
O Pharmacy: Estmated Costs				osts		O Laboratory / Radiolo	gy:	Estmated Costs		
			○ Surger	y:		O Endoscopy:	ndoscopy:			
			O Physiotherapy:			Other Procedures:				
						If yes please specify				
	Required ? Len			ra corract	Indicate Provider Estimate Cost I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizat					
						y informaton regarding n			_	
						se of determining insura				
this case.					responsibility	of doctor and the paten	t.			
Treating Physician Name : <b>Humaira</b>										
Tel / Fax (imp	oortant):	We.								
General P DHA No: 54 Citicare Medic		April 1	101		Patient's Signa Date: 31-Jan	ature(Parent if minor)				
	s must ha suhi	mited alor	ng with sun		1	-2025 a 30 days from date of se	rvice			
ivote. Claiili	a muat be subi	iiiicu diül	ig with Sup	porting doct	ATTICITES WILLIIII	i 30 days from date of se	VICE			

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