eASOAP FORM

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

Patent Name:	**MUHAMMAD SAJID IHSAN MUHAMMAD IHSAN**	Gender:	**Male**	Validity Between:	**06/11/2024 and 05/11/2025**
Card No:	**I008-002-121620381-01**	DOB:	**3/23/1992 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1992-2528574-3**	Service Date:	**09-Feb-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0557564845**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45799**	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 : cough with sputum, fever, snezing , runny ose for 1 week , epigastric pain , for 1 week nausea for 1 week family hx of htn smokes ciggs o/e : bp is elevated hypermic pharynx chest congested			

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 : 140 T : 36.4 HR : 88 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R03.0	Elevated blood-pressure reading, w/o diagnosis of htn
Secondary	J45.991	Cough variant asthma
Secondary	J01.90	Acute sinusitis, unspecified
Secondary	R50.9	Fever, 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 Consultation	25.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
4235-533801-1751	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG GASTRO-RESISTANT TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) morning empty stomach
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) evening
0005-119805-1174	(PREDNISOLONE : 5 MG TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) others
0837-277601-1161	(OXOMEMAZINE : 0.33 MG/ML) SYRUP	7	Take 1Syrup 2 Time(s) per Day For 7 Day(s) others
0006-104201-1161	(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	7	Take 1Syrup 2Time(s) perDay For 7 Day(s) others

○ 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 : **DR Amaizah**	
Tel / Fax (important):	

Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)***
Date :	Date : 09-Feb-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	