

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	SULTAN UR REHMAN SULTAN UR REHMAN	Gender:	Male	Validity Between:	24/05/2024 and 23/05/2025
Card No:	369C-E22A-0EB7-08AB	DOB:	1/1/1998 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1998-3084159-1	Service Date:	28-Feb-2025	Radiology:	Covered
		Patent's Tel No:	0545431803		
Policy Holder:		Threshold Limit:			
Payer Name:	UNION INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43897	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
PATIENT CAME WITH THE COMPLAIN OF THROAT PAIN ALONG WITH ABDOMINAL PAIN AND CONSTIPATION							
OE THROAT IS HYPEREMIC							
ABDOMEN IS TENDER							
NO GAS PASS							
ALSO COMPLAIN OF DARK COLOUR URINE ALONG WITH LOWER BACK PAIN							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					DD	MM	YYYY
Obs/Gyn Claims					Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:					DD	MM	YYYY
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 : 36.1 HR : 72 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	R12	Heartburn	
Secondary	K59.00	Constipation, unspecified	
Secondary	R11.2	Nausea with vomiting, unspecified	
Secondary	J03.90	Acute tonsillitis, unspecified	

Type	Code	Diagnosis
Secondary	K29.00	Acute gastritis without bleeding
Secondary	N39.0	Urinary tract infection, site not specified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

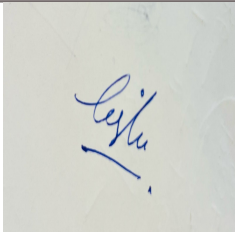
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
7024-037801-4021	(D-MANNOSE : 1.5 G) (EXOCYAN DRY CRANBERRY EXTRACT (VACCINIUM MACROCARPON) : 0.072 G) POWDER FOR ORAL SOLUTION	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
1654-525701-1091	(CHARCOAL, ACTIVATED : 250 MG) (SIMETHICONE : 80 MG) SUGAR-COATED TAB	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0270-189301-0081	(ALUMINIUM HYDROXIDE : N/A) (SODIUM BICARBONATE : N/A) (ALGINIC ACID : N/A) (MAGNESIUM TRISILICATE : N/A) CHEWABLE TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
6445-533801-1561	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others BEFORE MEAL
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>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 : AISHA		
Tel / Fax (important):		
 Signature & Stamp Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E		 Patient's Signature(Parent if minor)
Date :		Date : 28-Feb-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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