eASOAP FORM

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

Patent Name:	**JANNAT FIRDOS**	Gender:	**Female**	Validity Between:	**21/11/2024 and 20/11/2025**
Card No:	**1EAD-3006-24FA-8133**	DOB:	**8/15/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1990-2099027-3**	Service Date:	**01-Mar-2025**	Radiology:	**Covered**
		Patent's Tel No:	**000000**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46017**	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 WEAKNESS GENERALIZE BODY PAIN PATIENT HAS EXTERNAL HEMORRHOID AND INTERNAL HEMORRHOID HISTORY OF IBS			

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 : 127 T : 37.2 HR : 82 RR : 0

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K64.9	Unspecified hemorrhoids
Secondary	E86.0	Dehydration
Secondary	K58.8	Other irritable bowel syndrome

Type	Code	Diagnosis
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:		

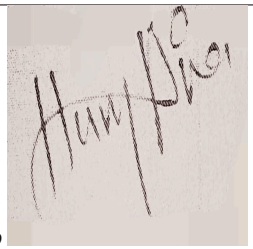
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-149902-1021	CLOFEN	Pharmacy	6.5000

Code	Generic	Duration	Instructions
0102-142201-0391	(DICLOFENAC POTASSIUM : 50 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
1190-170813-1161	(LACTULOSE : 667MG/G) SYRUP	10	Take 1Syrup 1 Time(s) per Day For 10 Day(s) others NIGH
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 2sachet 2 Time(s) per Day For 5 Day(s) others
0071-158501-0391	(HESPERIDIN : 50 MG (DIOSMIN (FLAVONOIDIC FRACTION : 450 MG FILM COATED TABLETS	15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) others
0016-119401-2231	(ZINC OXIDE : 296 MG) (BALSAM PERUVIAN SINE RESINA : 49 MG) (BISMUTH OXIDE : 24 MG) (BISMUTH SUBGALLATE : 59 MG) RECTAL SUPPOSITORIES	10	Take 1Suppository 2 Time(s) per Day For 10 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 : **Humaira**		
Tel / Fax (important):		

Signature & Stamp  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 01-Mar-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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