eASOAP FORM

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

Patent Name:	**MUHAMMAD SULEMAN IKRAM BABU IKRAM**	Gender:	**Male**	Validity Between:	**30/12/2024 and 29/12/2025**
Card No:	**8197-1CEC-D61A-3F01**	DOB:	**2/29/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-8097847-7**	Service Date:	**03-Mar-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0522632143**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Orient insurance PJSC Worldwide E-Rx**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46029**	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 : TINGLING SENSATION , MUSCLE WEAKNESS , AND DIZINESS, FROM FEW WEEKS CONSTIPATION AND SENSE OF FULLNESS STARTED 2/03/25 RAISED BP O/E : LOOK LETHARGIC DEHYDRATED			

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 : 139 T : 36 HR : 85 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	K29.00	Acute gastritis without bleeding
Secondary	R05	Cough

Type	Code	Diagnosis
Secondary	K59.00	Constipation, unspecified

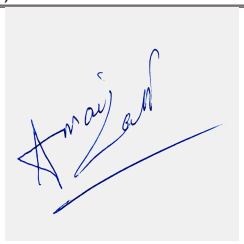
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

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
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000

Code	Generic	Duration	Instructions
1291-170801-1161	(LACTULOSE : 66.7% SYRUP	5	30
1195-926901-0391	(VITAMIN D3 : 5 MCG) (VITAMIN E (AS D-ALPHA TOCOPHERYL SUCCINATE) : 20 MG) (ZINC : 15 MG) (CHROMIUM : 50 MCG) (COPPER : 1 MG) (VITAMIN B12 : 9 MCG) (FOLACIN : 500 MCG) (SIBERIAN GINSENG (ELEUTHEROCOCCUS SENTICOSUS) : 20 MG) (IODINE : 150 MCG) (IRON (FERROUS FUMARATE) : 6 MG) (MAGNESIUM OXIDE : 50 MG) (MANGANESE SULFATE : 3 MG) (L-METHIONINE : 20 MG) (NIACIN : 20 MG) (PANTOTHENIC ACID : 10 MG) (PABA : 20 MG) (PYRIDOXINE (VITAMIN B6) : 9 MG) (VITAMIN B2 (RIBOFLAVIN) : 5 MG) (SELENIUM : 150 MCG) (S	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
1267-141614-1112	(ALUMINIUM HYDROXIDE : 225 MG/5ML (SIMETHICONE : 25 MG/5 ML (MAGNESIUM HYDROXIDE : 200 MG/5ML SUSPENSION	10	Take 1 Unit(s), 2 Time(s) per Day For 10 Day(s)

◯ 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 : 03-Mar-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.