eASOAP FORM

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

Patent Name:	**JANIDU BINULSHA PATHMABANDU**	Gender:	**Male**	Validity Between:	**06/08/2024 and 05/08/2025**
Card No:	**51E2-B46B-4867-D3F1**	DOB:	**10/1/2015 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2015-5925025-9**	Service Date:	**05-Mar-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0559360233**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46057**	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 HIGH GRADE FEVER .RUNNY NOSE ,ALONG WITH CHEST CONGESTION CHEST IS CONGESTED .WHEEZING AUTISTIC CHILD HAVING ASTHMA			

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 : 00	T : 37.8	HR : 99	RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	J45.991	Cough variant asthma
Secondary	J30.9	Allergic rhinitis, 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:

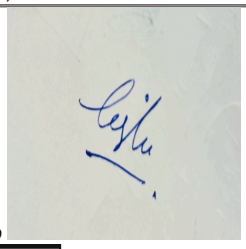
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

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

Code	Generic	Duration	Instructions
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	5	Take 1Solution 2 Time(s) per Day For 5 Day(s) others
0005-116901-2471	(SODIUM CITRATE : 28.5 MG/5 ML (MENTHOL : 0.55 MG/5 ML (DIPHENHYDRAMINE : 7 MG/5 ML SYRUP (ALCOHOL FREE	5	Take 1Syrup 2 Time(s) per Day For 5 Day(s) others 5ML
0005-127401-0851	(AZITHROMYCIN : 200 MG/5ML POWDER FOR SUSPENSION	5	Take 1Syrup 2 Time(s) per Day For 5 Day(s) others 6ML
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	3	Take 4 ML Syrup 2 Time(s) per Day For 3 Day(s) others
0006-106607-1161	(PARACETAMOL : 240 MG/5ML) SYRUP	5	Take 1Syrup 3 Time(s) per Day For 5 Day(s) others
0005-107904-1113	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 6 ML Syrup 2 Time(s) per Day For 5 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 : **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 : 05-Mar-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		