Laboratory:

ADMINISTRATIVE

eASOAP FORM



at the CITICARE MEDICAL CENTER LLC

Covered

Patent Name: **BABU ENGANDIYUR** Gender: Male Validity Between: 07/08/2024 and 06/08/2025 Coverage Informaton 5/23/1976 12:00:00 7DA4-8F92-AFD3-0D35 Card No: DOB: **Out Patient** RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-1976-4183541-4 Service Date: 26-Apr-2025 Radiology: Covered Patent's Tel No: 0586175574 Threshold Policy Holder: Limit: MEDGULF - THE **MEDITERRANEAN** and **GULF INSURANCE and** Normal Payer Name: Class: REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH) Out-Patent: Patent's File 43480 Category: **Category B** Pharmacy: Co-Part: 20%

The member is allowed for Out Patient

No:

Consultation:

No

Gatekeeper:

Referral No: Referred Service:

SUBJECTIVE AS	SESSMI	ENT									
Symptom(s) a	descri	bed by the pa	atent (Cl	nief Complaint	i):			Date of	Symptoms/	illness started	
Complaint								DD	MM	YYYY	
swelling and pus discharge ob the upper back since few day											
oe there is swelling and pussy discharge .											
known case of diabeties											
crp high											
Past Medical Surgical History?				○Yes		○ No	Date o	Date of Symptoms/illness started			
					10 103		0 110	DD	MM	YYYY	
									•	/	
Obs/Gyn Claims								Date o	MM	/illness started	
☐ Para ☐ Gravida: ☐ AB			□ АВ:	LMP:	Marital Statu	161	Marital Date:	DD DD	IVIIVI	1111	
∪ Pala	Gravida: AB: LMP:		iviaritai Status.		Marital Date.	-					
What date did t	he Patie	nt first feel sar	me / simi	lar Symptom(s) : dd mm yyy	'V					
Is the Patient u	nder any	type of Treat	ment?	Yes O No	if yes, indica	ite what Asses	ssment and since w	/hen:			
OBJECTIVE / A		•									
Clinical Findin		WIENT (10 De C	ompiete	u by Physician)	1	Vital Ciana	D/D . 1EE	T: 36.1	HR : 78	8 RR	
Cililical Fillulligs .					Vital Signs : B/P : 155 T : 3 : 18			1.30.1	пк. /	o nn	
Assessment/D	iaanosi	s: OAc	uto	O Chronic	O Confirm	ed OSusp	ected				
		DIAGNOSIS			- CO	- Cusp					
Туре		Code		Diagnosis							
Primary		L03.90		Cellulitis, unspecified							
Secondary -		T81.31XS		Disrupt of external operation (surgical) wound, NEC, sequela							
Secondary		R52		Pain, unspecified							
ACCIDENT/OC	CLIPATIO	ONAL Claim I	nformat	ton (complete	if claim is a r	esult of accid	ent or work relate	d illness/iniu	rv)		
ACCIDENT/OC		JITAL CIGIIII I	oiiiiai	on (complete		court or acciu	CIT OF WORK I CIALE	a miless/mju	• 7 /		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim CPT Code 16030 Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area) Code Generic Duration Instructions No Prescriptions History Found Strated Costs Surgery: Surgery: Physiotherapy: Physiotherapy: Physiotherapy: If yes please specify Indicate Provider I hereby certfy that all informaton mentoned are correct to that the medical services shown on this form were medically indicated & necessary for the management of the purpose of determining insurance benefts. Medical management is the sole	Accident or illness due to work?				accident?	to road	Describe how the accident or work related injury/illness occur:				
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Type Price Treatment Type Price Treatment Type Price Tode Tode Treatment Type Price Tode Tode Treatment Type Price Tode Tode Toda Prescriptions price than 10% total body surface area) Toda Prescriptions History Found Toda Pharmacy: Estmated Costs Surgery: Physiotherapy: Physiotherapy: Physiotherapy: Toda Provider Toda Provid	○ Yes ○ No ○ Yes				○ Yes ○	No	Ì				
Treatment Type Price	Date of accident or beginning of illness:						1				
Treatment Type Price	MEDICAL P	PLAN Itemized	Original In	voices and	Applicable P	rescriptions ,	/ Reports / Results must I	oe enclosed	to consider cla	im	
Code Generic Duration Instructions No Prescriptions History Found Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs	11	Treatment	Treatment							Туре	Price
No Prescriptions History Found Pharmacy: Estmated Costs Caboratory / Radiology: Estmated Costs	II I6030 °						nitial or subsequent; larg	e (eg, more	than 1	Co.Pay	75.0000
No Prescriptions History Found Pharmacy: Estmated Costs Caboratory / Radiology: Estmated Costs	Codo		Conoris			Duration		Instruction			
Pharmacy: Estmated Costs		intions History				Duration		Instructions			
Surgery: Other Procedures: If yes please specify Sin-patient Required ? Length of Stay 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. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Aisha Uner Physician Geneti Pacifilms Dith - 403/189-002 Citticare MEDICAL CENTER DIBAI - LLAE Patient's Signature(Parent if minor) Date : 26-Apr-2025		· · ·	round	1					1		
Indicate Provider Indicate Prov	O Pharma	acy:		Estmated	Costs		Caboratory / Radiology:		Estmated Costs		
If yes please specify Indicate Provider Indicate				Surger	y:		○ Endoscopy:				
Indicate Provider I hereby certfy that all informaton mentoned are correct I hereby certfy that all informaton mentoned are correct I hereby certfy that all informaton mentoned are correct I hereby certfy that all informaton mentoned are correct I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Tealing Physician Name: AISHA Tel / Fax (important): Signature & Stamp Dr. Aisha Umer Physician General Practitione DRA-403149-002 CITICARE MEDICAL CENTER DUBN-U.A.E. Patient's Signature(Parent if minor) Date: 26-Apr-2025				OPhysic	therapy:		Other Procedures:				
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. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Alsha Uner Physician Geneal Practitions DHA 4031439-002 CITICARE NEDICAL CENTER DUBA! U.A.E Patient's Signature(Parent if minor) Date : Date : Date : 26-Apr-2025							If yes please specify				
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. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Alsha Uner Physician Geneal Practitions DHA 4031439-002 CITICARE NEDICAL CENTER DUBA! U.A.E Patient's Signature(Parent if minor) Date : Date : Date : 26-Apr-2025											<u> </u>
Signature & Stamp Dr. Aisha Umer Physician- General Practitioner OHA- 40131439-002 CITICARE MEDICAL CENTER OUBAI- U.A.E Patient's Signature(Parent if minor) Date: Date: Date: 26-Apr-2025	& that the medically in this case.	medical service	es shown c essary for	on this forn	n were gement of	release any ir the purpose c	nformaton regarding my of determining insurance	medical con benefts. Me	diton and histo	ry to NEX	tCARE for
Signature & Stamp Dr. Alsha Umer Physician- General Practitioner DHA 40131439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Patient's Signature(Parent if minor) Date: Date: Date: 26-Apr-2025		•	AISHA								
Dr. Aisha Umer Physician- General Practitioner DHA-40131439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Patient's Signature(Parent if minor) Date: Date: 26-Apr-2025			Lejlu.								
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