## **eASOAP FORM**



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

Patent Name:	TAIMOOR KHAN LODHI MUHAMMAD SHUJAAT KHAN	Gender:	Male	Validity Between:	01/07/2024 and 16/05/2025
Card No:	53E0-467F-9ECC-8F92	DOB:	7/22/1997 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1997-3357882-9	Service Date: Patent's Tel No:	13-May-2025 0588318322	Radiology:	Covered
Policy Holder:		Threshold Limit:			
Payer Name:	Islamic Arab Insurance Co. (P.S.C.	Class:	Normal		
Category:	Category B	Out-Patent : Patent's File No:	39365	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No: Referred Service:					

Referral No:										
Referred										
Service:										
SUBJECTIVE A	ASSESSMENT									
Symptom(s)	as described by the	patent (Chie	f Complaint	t):				Date of	Symptoms	s/illness started
Complaint								DD	MM	YYYY
BSR=106										
weakness										
numbness	n hands and feet.									
history of lo	ow level of sugars									
								Date of	Symptom	 s/illness started
Past Medical	Surgical History?			○Yes		○ No		DD	ММ	YYYY
Obs/Gyn Clai	ms								7	s/illness started
	ĪO	10	l	l		l		DD	MM	YYYY
☐ Para	Gravida:	AB:	LMP:	Marital Status	5:	Marital Date:				
What date did	the Patient first feel	same / similar	Symptom(s	) . qq mm vvvv	,					
	under any type of Tre					ssment and since	e when:			
				•						
Clinical Findi	ASSESSMENT(To b	e completea i	by Physician)		Vital Signs :	B/D · 126	T:3	6.6	HR:	78 R
					: 18	D/1 . 120	1.3	0.0		70 K
Assessment/	Diagnosis : O		Chronic PTOM	O Confirme	d O Susp	ected				
Туре			Code		Diagnosi	is				
Primary			R25.2		Cramp a	nd spasm				
Secondary			R53.1		Weaknes	SS				
Secondary E86.0				Dehydration						
Secondary			R52		Pain, uns	specified				
ACCIDENT/O	CCUPATIONAL Clair	n Informato	n (complete	if claim is a re	sult of accid	lent or work rel	lated illne	ss/injur	y)	
Accident or i	lness due to work?		Injury due accident?		Describe ho	ow the accident	or work i	elated ir	njury/illne	ss occur:
○ Yes ○ No ○ Yes ○			No							
Date of accid	ent or beginning of	illness:			1					
MEDICAL PLA	AN Itemized Origina	I Invoices and	d Applicable	Prescriptions	/ Reports / R	lesults must be	enclosed	to consi	der claim	

Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  CO.Pay 10.000  10.0005-149902- 10.01  CLOFEN Pharmacy 6.5000  Pharmacy C.O.Pay 25.000  10439-152905- 1001  LACTATED RINGERS INJECTION USP Pharmacy 5.0000  Code Generic Duration Instructions  O Prescriptions History Found  Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs  O Surgery: Dendoscopy: Physiotherapy: Dendoscopy: Dendoscopy: Physiotherapy: Dendoscopy: Dendoscopy: Physiotherapy: Dendoscopy:	CPT Code	Treatment				Туре	Price		
subcutaneous or intramuscular  CLOFEN  Pharmacy 6.5000  1001  Pharmacy 6.5000  A339-152905- LACTATED RINGERS INJECTION USP  Pharmacy  LACTATED RINGERS INJECTION USP  Pharmacy 5.0000  Code Generic Duration  Pharmacy: Estmated Costs  Surgery: Physiotherapy: Physiotherapy: Physiotherapy: Inpatient Required? Length of Stay Inpatient Required? Length of Stay Indicate Provider  Indicate Provider, Insurer, Employer or other Organizator to release any information nemtoned are correct that the medical services shown on this form were edically indicated & necessary for the management of scase.  Bailing Physician Name: Dr.Farhan lyas  In Fax (important):  Patient's Signature(Parent if minor)  Patient's Signature(Parent if minor)	9	GP Consultation	on					25.0000	
Code Generic Duration Instructions O Prescriptions History Found O Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs O Prescriptions required Physiotherapy: Other Procedures: In-patient Required ? Length of Stay Indicate Provider Estimate Cost to release any information regarding my medical condition and history to NEXCARI for the purpose of determining insurance benefts. Medical management is so so so.  In-patient Required & Stamp  Dr. Frahan lyas  In Frak (important):  Patient's Signature(Parent if minor)  Pharmacy 6.5000 Co.Pay 25.000 Co.P	96372			stic injection (specify substance or drug);			Co.Pay	10.0000	
Descriptions History Found    Code   Generic   Duration   Instructions	0005-149902- 1021	CLOFEN					Pharmacy	6.5000	
Code Generic Duration Instructions    Pharmacy   Duration   Descriptions History Found	96360	Intravenous in	fusion, hydration; initi	al, 31 minutes to 1 hour			Co.Pay	25.0000	
Departmency:  Estmated Costs  Surgery: Departmency: Depar	0439-152905- 1001	LACTATED RIN						5.0000	
Departmency:  Estmated Costs  Surgery: Departmency: Depar									
Pharmacy: Estmated Costs	Code	Generic		Duration		Instruction	ructions		
Surgery:    Physiotherapy:   Other Procedures:	No Prescriptions H	History Found							
In-patient Required Physiotherapy: Other Procedures: If yes please specify  In-patient Required ? Length of Stay Indicate Provider In-patient Required ? Length of Stay Indicate Provider In-patient Required ? Length of Stay Indicate Provider Indicate Provider Indicate Provider Insurer, Employer or other Organizator In the redical services shown on this form were deficially indicated & necessary for the management of is case. In the redical services shown on this form were deficially indicated & necessary for the management of is case. In the redical services any information regarding my medical condition and history to NEXtCARI for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.  In the redical services shown on this form were deficially indicated & necessary for the management of is case. In the redical services shown on this form were deficially indicated & necessary for the management of to release any information regarding my medical condition and history to NEXtCARI for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.  In the redical services shown on this form were deficially indicated & necessary for the management of to release any information regarding my medical condition and history to NEXtCARI for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.  In the redical services shown on this form were to release any information regarding my medical condition and history to NEXtCARI for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.  In the redical services shown on the redical services and in the redical servic	O Pharmacy:		Estmated Costs		C Laboratory / Radiology:		Estmated Costs		
In-patient Required? Length of Stay Indicate Provider Indicate Pro			O Surgery:		O Endoscopy:				
Indicate Provider Indicate Pro	s the following red	quired	O Physiotherapy:		Other Procedures:				
hereby certfy that all informaton mentoned are correct that the medical services shown on this form were edically indicated & necessary for the management of is case.  Jealing Physician Name: Dr.Farhan lyas  If Fax (important):  Dr. Frahan lyas Malik hysician-General Practitioner DHA-06441782-001  ITICARE MEDICAL CENTER  DUBAI U.A.E  Jereby authorize any Healthcare Provider, Insurer, Employer or other Organizator to release any informaton regarding my medical condition and history to NEXtCARB for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.  Jereby authorize any Healthcare Provider, Insurer, Employer or other Organizator to release any informaton regarding my medical condition and history to NEXtCARB for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.					If yes please specify				
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Dr .Frahan Ilyas Malik hysician-General Practitioner DHA-06441782-001 ITICARE MEDICAL CENTER DUBAI U.A.E  Patient's Signature(Parent if minor)	el / Fax (important)	:		ļ					
	Physician-General Practit DHA-06441782-001 CITICARE MEDICAL CENTE	ioner	e con la constant de	Patient's Sign					
ate: Date: 13-May-2025									

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