eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**AISHA UMER M UMER BIN NASSEM SIDDIQUI**	Gender:	**Female**	Validity Between:	**31/07/2024 and 30/06/2025**
Card No:	**78A9-4E8D-70EC-A913**	DOB:	**6/7/1994 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1994-5758075-3**	Service Date:	**27-May-2025**	Radiology:	**Covered**
		Patent's Tel No:	**971585633517**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46156**	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
PT CAME WITH FEVER ,BODY PAIN MUSCLE SPASM OF SHOULDER FOR 2 DAYS			

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 : 109	T : 36.8	HR : 78	RR : 0

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	E78.5	Hyperlipidemia, unspecified
Secondary	R73.9	Hyperglycemia, unspecified
Secondary	D51.8	Other vitamin B12 deficiency anemias
Secondary	R50.9	Fever, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	E56.9	Vitamin deficiency, unspecified
Secondary	E83.51	Hypocalcemia
Secondary	E03.9	Hypothyroidism, unspecified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

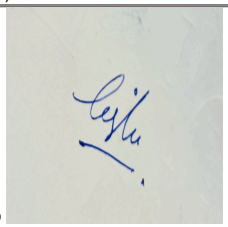
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
78220	Liver function study with hepatobiliary agents, with serial images	Radiology	200.0000
82310	Calcium; total	Lab	10.0000
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
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

Code	Generic	Duration	Instructions
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others
0435-189401-1113	(CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
1516-151709-0081	(SIMETHICONE : 42 MG) CHEWABLE TABLETS	15	Take 1Tablets 1 Time(s) per Day For 15 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 : 27-May-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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