eASOAP FORM

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

Patent Name:	**SAMIR DIGE ARUN SONU DIGE**	Gender:	**Male**	Validity Between:	**12/09/2024 and 11/09/2025**
Card No:	**I008-002-117012031-04**	DOB:	**6/21/1991 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1991-0843274-3**	Service Date:	**02-Jun-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0526196000**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45947**	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 high grade fever throat pain and generalize body pain oe throat is hyperemic chest is clear on investigation: neutrophils high CRP is high wbc high hair loss in beared in spot form			

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 : 126 T : 36.9 HR : 72 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	J02.9	Acute pharyngitis, unspecified

Type	Code	Diagnosis
Secondary	R53.1	Weakness
Secondary	E86.0	Dehydration
Secondary	L63.9	Alopecia areata, unspecified

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

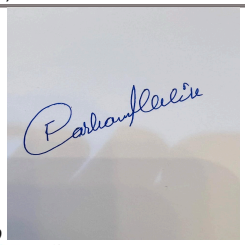
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000

Code	Generic	Duration	Instructions
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	7	Take 1Cream 2 Time(s) per Day For 7 Day(s) others
0186-140201-1451	(FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN)	7	Take 1Capsule 2 Time(s) per Week For 7 Day(s) others
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 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 : **Dr.Farhan Iyas**		
Tel / Fax (important):		
Signature & Stamp  Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 02-Jun-2025	

Note: Claims must be submited along with supportng documents within 30 days from date of service