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:	**04-Jun-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
pale looking frontal bossing picky eater height and weight less than 10th centile. needs evaluation of iron and vitamin D deficiency.			
Autistic child pain in left cheek mucosa on exam: inflamed left cheek mucosa and hard palate lymph nodes not palpable abdomen: soft, non tender, no visceromegaly rest of systemic exam: unremarkable			

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 : 36.6	HR : 99	RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	B37.0	Candidal stomatitis
Secondary	E55.9	Vitamin D deficiency, unspecified
Secondary	E61.1	Iron deficiency

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:		

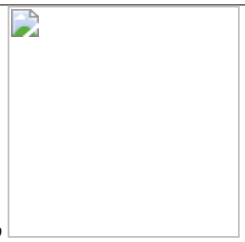
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
83540	Iron	Lab	20.0000
82728	Ferritin	Lab	20.0000
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Lab	100.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
2495-222102-1111	(NYSTATIN : 100000 IU/ML) SUSPENSION	5	Take 1Drops 2 Time(s) per Day For 5 Day(s) before meal
B30-3790-04103-01	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	5	Take 1Drops 2 Time(s) per Day For 5 Day(s) before meal
6706-154215-3931	(CHLORHEXIDINE : 0.12%) MOUTHWASH-SOLUTION	5	Take 1Solution 1 Time(s) per Day For 5 Day(s) before meal
0156-236401-0151	(CHLORHEXIDINE : 11.5 MG/G) (DEXAMETHASONE : 1 MG/G) (NYSTATIN : 100000 IU/G) CREAM	5	Take 1Ointment 2 Time(s) per Day For 5 Day(s) before meal
0415-140401-1781	(MICONAZOLE : 2%) GEL (ORAL)	7	Take 1Ointment 3 Time(s) per Day For 7 Day(s) before meal

○ 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 Bushra**		
Tel / Fax (important):		

Signature & Stamp  Dr. Bushra Mufti General practitioner DHA: 75646242-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 
Date :	Date : 04-Jun-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	