eASOAP FORM

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

Patent Name:	**AKHIL MANUEL**	Gender:	**Male**	Validity Between:	**24/09/2024 and 23/09/2025**
Card No:	**F24E-01C2-2856-1A89**	DOB:	**12/24/1985 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1985-9699906-4**	Service Date:	**08-Jun-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0521875899**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Yas Takaful P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45605**	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
some heaves seen over all over body which is typicallly urticaria in nature.								
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 : 113	T : 36.1	HR : 91	RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	L50.0	Allergic urticaria
Secondary	T78.40XS	Allergy, unspecified, sequela

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

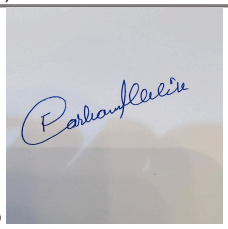
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9.01	Follow Up - Consultation GP	General Consultation	0.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000

Code	Generic	Duration	Instructions
0005-119803-1173	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal
0320-148701-1171	(LORATADINE : 10 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 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 : 08-Jun-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		