

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MUHAMMAD NADEEM MUHAMMED SHAFI	Gender:	Male	Validity Between:	07/01/2025 and 31/12/2025
Card No:	7E73-DC9E-27AE-44C1	DOB:	3/11/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1987-3737465-6	Service Date:	20-Jun-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0563714290		
		Threshold Limit:			
Payer Name:	DUBAI INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	47199	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC : WEAKNESS AND LEG PAIN HOPC : PT CAME WITH GENERALIZE WEAKNESS FEELING DIZZY ALL THE TIME FOR THE LAST ONE WEEK .HE FEELS IN ATTENTIVE ALL THE TIME .ALONG WITH LEG PAIN . O/E HE LOOKED DEHYDRATED . ALLEGIES : NONE PMH : NONE						DD	MM	YYYY
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 : 128		T : 36.2	HR : 66	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	I95.9	Hypotension, unspecified				
Secondary	E16.2	Hypoglycemia, unspecified				
Secondary	R53.1	Weakness				
Secondary	R52	Pain, unspecified				

Type	Code	Diagnosis
Secondary	E86.0	Dehydration

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

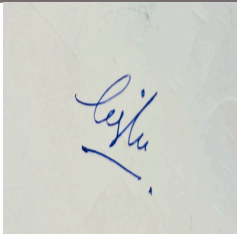
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
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
5254-830602-2401	(VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
2027-719101-0392	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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>		<i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>
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 : 20-Jun-2025

Note: Claims must be submitted along with supporting documents within 30 days from date of service

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