# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **CRISTOPHER SANTOS CARILLO** | Gender: | **Male** | Validity Between: | **27/03/2025 and 26/03/2026** |
| Card No: | **D391-3675-1BDD-4D68** | DOB: | **3/30/1976 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1976-8702716-5** | Service Date: | **18-Jul-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0551763059** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **47423** | 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 |
| pc : generalize joint pain<br>hopc :pt came with the complain of joints pain for the long the time ,<br>he has a history of high uric acid<br>he also has a history of fatty liver<br>pt also has a complain of runny nose and headache<br>allergies none<br>pmh : uric acid | | | |

| **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 : 120 | T : 36.8 | HR : 84 | RR : 18 |
|---|---|---|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | E78.01 | Familial hypercholesterolemia |
| Secondary | R73.9 | Hyperglycemia, unspecified |
| Secondary | J30.9 | Allergic rhinitis, unspecified |
| Secondary | R51.9 | Headache, unspecified |
| Secondary | K76.0 | Fatty (change of) liver, not elsewhere classified |
| Secondary | E79.0 | Hyperuricemia w/o signs of inflam arthrit and tophaceous dis |

| Type | Code | Diagnosis |
|---|---|---|
| Secondary | R30.0 | Dysuria |
| Secondary | R21 | Rash and other nonspecific skin eruption |

| 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

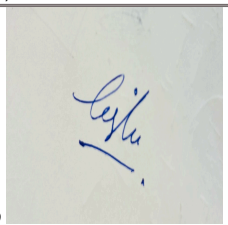
| CPT Code | Treatment | Type | Price |
|---|---|---|---|
| 9 | GP Consultation | General Consultation | 25.0000 |
| 82947 | Glucose; quantitative, blood (except reagent strip) | Lab | 12.0000 |
| 81003 | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy | Lab | 8.0000 |
| 80076 | Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450) | Lab | 85.0000 |
| 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 |
| 84550 | Uric acid; blood | Lab | 15.0000 |
| 86140 | C-reactive protein; | Lab | 15.0000 |
| 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 |
|---|---|---|---|
| 0006-149803-0151 | (CLOBETASOL PROPIONATE : 0.5 MG/G) CREAM | 5 | Take 1Cream 1 Time(s) per Day For 5 Day(s) others |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | 5 | Take 1Tablets 1 Time(s) per Day For 5 Day(s) others |
| 0069-108001-0111 | (IBUPROFEN : 200 MG) (PSEUDOEPHEDRINE : 30 MG) COATED TABLETS | 5 | Take 1Tablets 2 Time(s) per Day For 5 Day(s) others |
| 2359-112401-1171 | (ALLOPURINOL : 100 MG) TABLETS | 30 | Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) |

| ◯ 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 : 18-Jul-2025 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |