eASOAP FORM

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

Patent Name:	**AAMIR RASHEED MUHAMMAD RASHEED**	Gender:	**Male**	Validity Between:	**06/12/2024 and 05/12/2025**
Card No:	**7735-027D-BB72-9AEA**	DOB:	**4/4/1984 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1984-8194090-0**	Service Date:	**20-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0501440709**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47429**	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
Came for followup of general package Pt complaints of burning sensation in both feet since 3 months Vit D3 15.1 Hba1c 10.5 Triglyceride 245 FBS 101 He has started OHA 2 WEEKS BACK AND THE Hba1c dropped from 12 to 10.5			

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 : 36.8 HR : 94 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	E55.9	Vitamin D deficiency, unspecified

Type	Code	Diagnosis
Secondary	E11.9	Type 2 diabetes mellitus without complications
Secondary	E78.5	Hyperlipidemia, unspecified
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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

Code	Generic	Duration	Instructions
0042-538302-0391	(METFORMIN HCL : 850 MG) (LINAGLIPTIN : 2.5 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
1350-854601-0391	(EZETIMIBE : 10 MG) (ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0118-114201-1171	(GLIMEPIRIDE : 2 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0207-211505-1171	(FENOFIBRATE : 145 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
2693-382607-0971	(ERGOCALCIFEROL (VITAMIN D2) : 50000 IU) SOFT GELATIN CAPSULES	8	Take 1Tablets 1 Time(s) per Day per week For 8 weeks others
6189-909901-1171	(MECOBALAMIN : 0.5 MG) (FURSULTIAMINE HCL : 36.4 MG) (TOCOPHEROL CALCIUM SUCCINATE : 34.5 MG) (PYRIDOXINE HYDROCHLORIDE : 33.3 MG) (NICOTINAMIDE : 20 MG) (CALCIUM PANTOTHENATE : 15.4 MG) (GAMMA ORYZANOL : 3.3 MG) (FOLIC ACID : 0.3 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 : **KEERTHANA**		
Tel / Fax (important):		

Signature & Stamp

د. كيرثانا راني بادييورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مركز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Patient's Signature(Parent if minor)

Date :	Date : 20-Jul-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	