eASOAP FORM



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

	TAHER YU	ISUFALI								
Patent Name:	GADAWA	LA YUSUFALI LI GADAWALA	Gender:	Male		Validity Between:	01/05/2025 and 30/04/2026			
Card No:	D053-A64	1-A26D-0FEC	DOB:	4/13/2007 12:0 AM		Coverage Informaton for:	Out Pat			
Pin #:			Identty Card:			Network:	RN UAE MEDGU	E (Al Ansari- <i>A</i> JLF	AUH)-	
Natonal ID:	784-2007-	2921910-3	Service Date: Patent's Tel No	24-Jul-2025 : 0559556213		Radiology:	Covere	d		
Policy Holder:			Threshold Limit:							
Payer Name:	ORIENT INSURANCE P.J.S.C		Class: Normal							
			Out-Patent :							
Category:	Category	В	Patent's File No:	47459		Pharmacy:	Co-Part	:: 20%		
Gatekeeper:	No		Consultaton :			Laboratory:	Covered			
Referral No:										
Referred										
Service:										
SUBJECTIVE ASS	ESSMENT									
Symptom(s) as o	described b	y the patent (Ch	ief Complaint):				Date of	Symptoms/ill	ness started	
Complaint							DD	MM	YYYY	
chief complaint: came with sore throat started 5 days back 19/07/25 associated with dry cough, flu.										
on examination:										
short congosti	on and hun.	oromia								
chest congestion and hyperemia										
pain scale:4										
allergy: nil										
								ĺ		
Past Medical Surgical History?							T	llness started		
Tes NO							DD	MM	YYYY	
							Data of	Summtomo /ii	llness started	
Obs/Gyn Claims							DD DD	MM	YYYY	
Para	Gravida:		LMP: M	Marital Status:		Marital Date:				
		☐ AB:					1			
What date did the	Patient first	t feel same / simil	ar Symptom(s) : (dd mm yyyy			,			
Is the Patient und	er any type	of Treatment?	Yes ONo if	yes, indicate wh	nat Asses	sment and since when:				
OBJECTIVE / AS	SESSMENT	(To be completed	by Physician)							
Clinical Findings				Vital : 18	Signs :	B/P:100 T:	36.6	HR : 78	RR	
Assessment/Dia	gnosis : CATE DIAG	O Acute	Chronic (IPTOM		O Susp	ected				
Type Code		Diagnosis								
Primary		J06.9 Acute uppe		r respiratory infection, unspecified						
Secondary R07.0		Pain in throat								
Secondary R05		Cough								
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)										
Accident or illne		<u> </u>	Injury due to road		ow the accident or work related injury/illness occur:					
○Yes ○No			○ Yes ○ N	lo						
Date of accident	or beginni	ng of illness:	1 123 011							
			nd Applicable Pr	escriptions / Rer	ports / R	esults must be enclosed	d to consid	der claim		

If yes please specify If yes please specify If yes please specify Indicate Provider Indicate Provider Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organization to release any information mentioned are correct to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Indicate Provider Indicate Prov	CPT Code	Trea	tment						Туре	Price	
Source Code Generic Duration Instructions	9	GP C	onsultation					(General Consultation	25.0000	
Code Generic Duration Instructions 397-116207- (AMOXICILLIN: 500 MG) (CLAVULANIC ACID: 125 MG) FILM D195-123701- (CETIRIZINE HCL: 10 MG) FILM COATED TABLETS 0195-123701- (CETIRIZINE HCL: 10 MG) FILM COATED TABLETS 027-265802- (BUTAMIRATE DIHYDROGEN CITRATE: 0.15% W/V) SYRUP D167-1161 Surgery: Surgery: D17-1161 Surgery: D18-1161 Surgery: D19-1161 Surgery: Surgery: D19-1161 Surgery: Sur	86140	C-rea	active protein;					ı	Lab	15.0000	
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Surgery: Other Procedures: If yes please specify Indicate Provider Indicate Provide	(RI ITΔ MIR ΔTF		(BUTAMIRATE	DIHYDROGEN CITRATE	SYRUP	5					
Sin-patient Required? Length of Stay Indicate Provider Insurer, Employer or other Organizaton to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Indicate Provider Indicate Provide	OPharmacy	:		Estmated Costs		Claborator	O Laboratory / Radiology:		Estmated Costs		
Sin-patient Required? Length of Stay Indicate Provider Insurer, Employer or other Organizaton to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Indicate Provider Indicate Provide				O Surgery:		O Endoscopy:					
Indicate Provider Indicate Prov	s the followin	s the following required				Other Procedures:			1		
I hereby certfy that all informaton mentoned are correct to release any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. 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)						If yes please specify			1		
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medically indicated & necessary for the management of this case. Treating Physician Name: Dr.Farhan Iyas Tel / Fax (important): Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor)	•	•			I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton						
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)	k that the medical services shown on this form were				to release any informaton regarding my medical conditon and history to NEXtCARE						
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Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor)		cian Na	ame : Dr.Farhan	lyas	CSPONSIBILITY	oj doctor dile	tile pateri	·			
Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor)				•							
Patient's Signature(Parent if minor)	Dr .Frahan Ilya Physician-General DHA-0644178 CITICARE MEDICAI	amp s Malik Practitio 82-001 L CENTER	ner	i Cu							
Date : Date : 24-Jul-2025	DORAL O.A.F				Patient's Sign	ature(Parent if	minor)				
	Date :				Date : 24-Jul-2025						

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