eASOAP FORM

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

Patent Name:	**HANIA AHMAD AHMED NAWAZ**	Gender:	**Female**	Validity Between:	**09/12/2024 and 08/12/2025**
Card No:	**B873-B9F4-2994-D38C**	DOB:	**1/6/2023 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2023-7941827-4**	Service Date:	**25-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0551082308**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45978**	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 fever,loose stools,vomiting,cough HOPC she was in pakistan 2 days back.She had fever,loose motion,vomiting and cough since one week.She is not eating properly O\E child active and alert,dehydrated She was not drinking ors			

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 : 00 T : 37.7 HR : 102 RR : 24

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	R19.7	Diarrhea, unspecified
Secondary	R11.2	Nausea with vomiting, unspecified

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
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
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
1342-383401-0451	(LACTOBACILLUS ACIDOPHILUS : 107 MG) (BIFIDOBACTERIUM INFANTIS : 107 MG) (LACTOBACILLUS CASEI : 107 MG) (LACTOBACILLUS LACTIS : 107 MG) (BIFIDOBACTERIUM BIFIDUM : 107 MG) (BIFIDOBACTERIUM LONGUM : 107 MG) GRANULES	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others
0097-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	3	Take 1Solution 3 Time(s) per Day For 3 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 : **KEERTHANA**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 25-Jul-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		