

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	NAYAB GUL FAZAL UR REHMAN	Gender:	Female	Validity Between:	20/05/2025 and 19/05/2026
Card No:	AAE1-9865-CF74-C3AE	DOB:	2/11/1996 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	999-9999-9999999-9	Service Date:	26-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0507342796		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	47472	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 pc : low back pain and muscle spasm hopc : pt came with low back pain along with muscle spasm of neck started two months back she has a history vitamin d deficiency . allergies none family history htn/dm						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 : 110 T : 36.8 HR : 78 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	M54.5	Low back pain	
Secondary	M62.830	Muscle spasm of back	
Secondary	R52	Pain, unspecified	
Secondary	R30.0	Dysuria	
Secondary	E55.9	Vitamin D deficiency, unspecified	

Type	Code	Diagnosis
Secondary	K29.00	Acute gastritis without bleeding

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:		

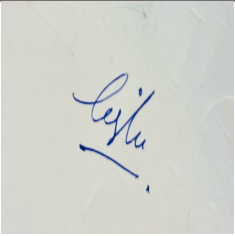
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
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

Code	Generic	Duration	Instructions
6619-548302-0251	(SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) empty stomach
0186-143702-0061	(CELECOXIB : 100 MG) CAPSULES	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	5	Take 1Gel 2 Time(s) per Day For 5 Day(s) others
0077-258502-1171	(SODIUM AESCINATE : 20 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 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>	<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 benefets. 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 : 26-Jul-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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