eASOAP FORM

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

Patent Name:	**Sultan Saeed Ahmad Ibrahim**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**BA3D-824C-CBCF-E4DA**	DOB:	**10/20/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1982-1858105-0**	Service Date:	**30-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0501577785**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**36472**	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 low back pain HOPC pt presented with complaints of low back pain since evening as he lifted weight He is a known case of ?disc prolapse L4-L5 treatment under orthopedic doctor No history of drug allergy Nil comorbs			

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 : 140 T : 36.2 HR : 74 RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	M54.5	Low back pain

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	Consultation GP	General Consultation	60.0000

Code	Generic	Duration	Instructions
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	3	Take 1Gel 2 Time(s) per Day For 3 Day(s) others
5278-596003-0431	(DICLOFENAC DIETHYLAMINE : 11.6 MG/ G) GEL	5	Take 1Gel 3 Time(s) per Day For 5 Day(s) others
4179-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	3	Take 1Tablets 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 : 30-Jul-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		