eASOAP FORM



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

Patent Name:	KUSHURU GODRE BHAGAT RUSTOM BHAGAT		Gender:	Male		Validity Between:	04/03	/2025 and 19/01/2	2026
Card No:	7A05-B10D-7C78-I	OOB:	1/19/1988 12 AM	2:00:00	Coverage Information for:	Out Patient			
Pin #:		le	dentty Card:			Network:		•	н)-
			Service Date: 31-Jul-2025 Patent's Tel No: 0558955659			Radiology:	Cove	red	
Policy Holder:			hreshold imit:						
Payer Name:	ORIENT INSURAN P.J.S.C	CE C	Class:	Normal					
			Out-Patent :						
Category:	Category B		Patent's File No:	47508		Pharmacy:	Co-Pa	art: 20%	
Gatekeeper:	No	C	Consultaton :			Laboratory:	Covered		
Referral No: Referred Service:									
SUBJECTIVE ASS									
Symptom(s) as	described by the pat	tent (Chief	f Complaint):				_		
Complaint							JUU	IVIIVI Y	YYY
bit swelling. on examinatio	nt: came with low ba n: a minor swelling s ry of hyperuricemia.	seen.	nce 2 days ass	sociated with tl	he pain in	the left leg, and a little			
Do at Mandinal Co.						Ī	Date o	of Symptoms/illn	ess started
Past Medical Su	rgical History?			○ Yes		No	DD	MM Y	YYY
Obs/Gyn Claims									
Para	Gravida:	AB:	LMP: N	/Jarital Status:		Marital Date:		IVIIVI	
					what Acco	sement and since when			
				i yes, iliulcate v	WIIdt ASSE	ssilient and since when.			
Clinical Finding	SESSMENT <i>(To be co</i> s :	ompietea b	y Pnysician)			B/P:120 T:	36.8	HR : 84	RR
Assessment/Dia	ignosis : O Acu	ıto C	Chronic	1/19/1988 12:00:00 AM For: Card: Network: Network: RN UAE (Al Ansari-AUH)- MEDGULF Covered Normal Normal Normal Pharmacy: Co-Part: 20% Aton: Laboratory: Covered Date of Symptoms/illness started DD MM YYYY Alloys associated with the pain in the left leg, and a little OPEN DATE of Symptoms/illness started DD MM YYYY No Do if yes, indicate what Assessment and since when: Isla Isla Decide of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No Date of Symptoms/illness started DD MM No No No No Date of Symptoms/illness started DD MM No No No No Date of Symptoms/illness started DD No No No No No Date of Symptoms/illness started DD No No No No No Date of Symptoms/illness started DD No No No No No No Date of Symptoms/illness started DD No					
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Туре	Code	Diag	gnosis						
Primary									
Secondary	E79.0	Нур	eruricemia w,	o signs of infla	am arthrit	and tophaceous dis			
Secondary	M79.605	Pain	in left leg						
ACCIDENT/OCC	UPATIONAL Claim In	formaton	(complete if	claim is a resu	ılt of accid	lent or work related illn	ess/inj	ury)	
Accident or illne	ess due to work?		Injury due to accident?	o road	escribe ho	ow the accident or work	related	injury/illness oc	cur:
○ Yes ○ No			○ Yes ○ No						
	t or beginning of illn		A		Name of 1-	Annual de la constant	d a .	atalau vietee	
		voices and	Applicable P	rescripπons / R	keports / F	kesuits must be enclosed	to con		1
CPT Code	,					Price			
9	GP Consultation								25.0000

or intramuscular O005- 149902- 1021 Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478) Lab 45.000 Code Generic Duration Instructions O097-142201- 0391 (DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS 5 Take 1Tablets 2 Time(s) per Day For 5 Day(s) others 2027-560101- 0391 (IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM 5 Take 1Tablets 3 Time(s) per Day For 5 Day(s) others Pharmacy: Estmated Costs	CPT Code	Treatment	Treatment							Price
149902- ILipid panel This panel must include the following: Cholesterol, serum, total (82465), Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718). Lab (45.000 ILipoprotein (15.000) Ilipoprotein (1	96372								,	10.0000
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O391 COATED TABLETS Day(s) others	(DICLOFENIAC POTASSILIM · 50 MG) F									
Surgery: Other Procedures: If yes please specify Indicate Provider Indicate Provi		,	10L : 500 MG)					per Day	For 5	
Other Procedures: If yes please specify Indicate Provider Indicate	O Pharmacy:		Estmated Costs		O Laboratory / Radiology: Estr			Estmated Cos	sts	
If yes please specify If yes please specify If yes please specify If yes please specify Indicate Provider Indicate Provider Indicate Provider Indicate Provider Insurer, Employer or other Organizator 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. Indicate Provider Indicate Provider Insurer, Employer or other Organizator 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. Indicate Provider Indicate Provider Insurer, Employer or other Organizator to release any informaton 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 Insurer, Employer or other Organizator to release any informaton 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 Insurer, Employer or other Organizator to release any informaton 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 Insurer, Employer or other Organizator 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. Indicate Provider Insurer, Employer or other Organizator to release any informaton regarding my medical condition and history to release any information regarding my medical condition and history to release any information regarding my medical condition and history to r			O Surgery:		○ Endoscopy:					
Inflicate Provider Indicate Pr	Is the following required		O Physiotherapy:	Other Procedures:			1			
hereby certfy that all informaton mentoned are correct to that the medical services shown on this form were nedically indicated & necessary for the management of its case. reating Physician Name: Dr.Farhan Iyas let / Fax (important): Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E. Date: 31-Jul-2025				If yes please specify			1			
hereby certfy that all informaton mentoned are correct to that the medical services shown on this form were nedically indicated & necessary for the management of its case. reating Physician Name: Dr.Farhan Iyas let / Fax (important): Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E. Date: 31-Jul-2025	e In-nationt Reg	uired 2 Length of Sta	V		Indicate Prov	rider			Eetin	nate Cost
reating Physician Name: Dr.Farhan lyas el / Fax (important): bignature & Stamp Dr. Frahan lyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor) Date: 31-Jul-2025	I hereby certfy t & that the medi	that all informaton cal services shown o	mentoned are correct on this form were	to release an	y informaton ose of determi	regarding n ning insurai	ny medical (nce benefts:	conditon and l	history to	o NEXtCARE
Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor) Pate: Date: 31-Jul-2025	reating Physicia	an Name : Dr.Farhan	lyas		,					
Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor) Date: 31-Jul-2025	Tel / Fax (importa	ant):								
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Date : 31-Jul-2025	Physician-General Pro DHA-06441782- CITICARE MEDICAL CI	actitioner 001		Potiont's Simo	oturo/Pot	E)				
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