## **eASOAP FORM**



ADMINISTRATIVE The member is allowed for **Out Patient** 

at the CITICARE MEDICAL CENTER LLC

	AZHARUDDIN							
Patent Name:	MOHAMMAD MOHAMMAD MASIUDDIN	Gender:	Male	Validity Between:	01/03/20	25 and 28/02	2/2026	
Card No:	B32E-FB03-AC97-6FBB	DOB:	4/15/1986 12:00:00 AM	Coverage Information for:	Out Pat	ient		
Pin #:		Identty Card:		Network:	RN UAE MEDGU	(Al Ansari-A LF	UH)-	
Natonal ID:	784-1986-5827542-9	Service Date: Patent's Tel No:	04-Aug-2025 0554780238	Radiology:	Covered	i		
Policy Holder:		Threshold Limit:						
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal					
		Out-Patent :						
Category:	Category B	Patent's File No:	47542	Pharmacy:	Co-Part	: 20%		
Gatekeeper:	No	Consultaton :		Laboratory:	Covered	ı		
Referral No:								
Referred								
Service:								
SUBJECTIVE ASSESSMENT								
Symptom(s) as described by the patent (Chief Complaint):  Date of Symptoms/illness started								
Complaint DD MM YYYY								

- 3		- <b>)</b>			7-				- 7		
Complaint	mplaint							DD	MM	YYYY	
PC fever,chills,weakness,runny nose											
HOPC pt pres	sented with (	complai	nts of fever	with chills,	bodypain,we	akness and ru	nning nose since 3				
O\e Chest cle	ear He looks	pale an	d tired								
No history of	f drug allergy	,									
Previous hist	ory of hyper	lipidem	ia present								
Past Madical S	Oct Madical Supplied History 2						Date of	Symptoms	/illness started		
Past iviedical s	Past Medical Surgical History?				○ Yes		○ No	DD	MM	YYYY	
Obs/Gyn Claims								-	Date of Symptoms/illness started		
							DD	MM	YYYY		
□ Para	☐ Gravida:		☐ AB:	LMP: Marital Statu		us:	Marital Date:				
What date did t	he Patient firs	t feel sa	me / similar :	Symptom(s)	) · dd mm yyy	//					
						•	ssment and since whe	n·			
						ite What Asses	sillent and since whe	11.			
OBJECTIVE / A		T(To be	completed by	/ Physician)		·					
Clinical Findings :						Vital Signs : : 18	B/P:110 T	: 37.7	HR : 9	98 RR	
Assessment/D INI	iagnosis : DICATE DIAG	O AG		Chronic TOM	O Confirm	ed OSusp	ected				
Туре		Code		Diagnosis							
Primary		E78.5		Hyperlipidemia, unspecified							
Secondary		R50.9		Fever, unspecified							
Secondary		R52		Pain, unsp	pecified						
Secondary		R53.83	L	Other malaise							

9 GP Consultation General Consultation 25.00 96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure) 96362 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); subcutaneous or intramuscular up to 1 hour (List separately in addition to code for primary procedure) 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour up to 1 hour (LOFIDE: N/A) (SODIUM CHLORIDE: N/A) (SODIUM CHLORIDE: N/A) (SODIUM CHLORIDE: N/A) (SODIUM CHLORIDE: N/A) (SODIUM LACTATE: N/A) SOLUTION Pharmacy 5.000 96364 LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE: N/A) (SODIUM LACTATE: N/A) SOLUTION Pharmacy 5.000 96372 (POTASSIUM CHLORIDE: N/A) (SODIUM CHLORIDE: N/A) (SODIUM LACTATE: N/A) SOLUTION Pharmacy 5.000 96384 LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE: N/A) (SODIUM LACTATE: N/A) SOLUTION Pharmacy 5.000 1002 FOR INFUSION SOLUTION FOR INFUSION (SOOML, BOTTLE) 5.000 1003-12190- 100618- 100618- 1001 Pharmacy 8.400 1004 Pharmacy 8.400 1005 Pharmacy 8.400 1006 Generic Duration Instructions 1.000 1007 Lab 1.000 1008 Generic Duration Instructions 1.000 1008 Generic Duration Instructions 1.000 1009 Pharmacy 1.0000 1009 Pharmacy 1.00000 1009 Pharmacy 1.00000 1009 Pharmacy 1.0000	Туре		Code		Diagnosis							
Accident or illness due to work?   Injury due to road accident?   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   No   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   O'es   Oescribe how the accident or work related injury/illness occurs   Oescribe how the accident or work related injury/illness occurs   Oescribe how the accident or work related injury illness   Oescribe to be accident or work related injury illness   Oescribe how the accident or work related injury illness   Oescribe how the accident or work relations     Oescribe how the accident or be proceded   Oescriber   Oescriber	Secondary		J06.9		Acute upper respiratory infection, unspecified							
Describe how the accident or work related injury/illness occurs   Ves   No     Ves   No	ACCIDENT/OCCI	UPATION	AL Claim II	nformaton (	complete i	f claim is a re	sult of ac	cident or w	ork related illne	ess/inj	ury)	
Are of accident or beginning of illiness:  AREDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim  APPLICATION Treatment  GPT Code Treatment  Price  General Consultation  General Consultation  General Consultation  Co.Pay  3.000  1ntravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)  Fragmentic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular intramuscular intramuscular  General Consultation  Co.Pay  10.00  General Consultation  Co.Pay  10.00	Injury due to road  Describe how the accident or work related injury/illness occur:									ccur:		
ACDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim  CPT Code Treatment General Consultation General Consultation   Type   Price General Consultation   Septiment   Septiment	○ Yes ○ No				○ Yes ○	No						
Price or Code   Treatment   Type   Price   Pr	ate of accident	t or begin	ning of illn	iess:								
9 GP Consultation  General Consultation  10 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)  96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)  96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intramuscular  96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous or drug, initial, procedure intravenous or drug); initial, prophylaxis, or diagnosis (specify substance or drug); initial, procedure intravenous or drug); initial,	IEDICAL PLAN I	Itemized (	Original In	voices and A	Applicable I	Prescriptions /	/ Reports	/ Results m	ust be enclosed	to cor	sider claim	
9 GP Consultation   25.00.   96361   Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure) 96372   Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular   10.00   96365   Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour   40.00   0005-	CPT Code	Treatme	nt								Туре	Price
primary procedure)  102. Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular intramuscular co. Pay 10.00  10365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour  1005- 1005- 1021 CLOFEN Pharmacy 6.500  10384 LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) 1002 FOR INFUSION SOLUTION FOR INFUSION (SODMIM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION Pharmacy 5.000  1002 FOR INFUSION SOLUTION FOR INFUSION (SOOML, BOTTLE)  1190- 106618- 106618- 106618- 106618- 106618- 106618- 106618- 10618- 106619- 10661	9	GP Consu	ultation									25.0000
intramuscular    CO.Pay   10.00	4h3h1				n; each add	litional hour (I	List separ	ately in add	ition to code for	r	Co.Pay	3.0000
up to 1 hour  Co.Pay 40.00  0005- 149902- CLOFEN  Rharmacy 6.500  1021  384- LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) 207801- (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION Pharmacy 5.000  FOR INFUSION SOLUTION FOR INFUSION (SOOML, BOTTLE)  2190- 106618- PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.400  85025 Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count  Code Generic Duration Instructions  0248-106304- (ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others  0133-127405- 0391  (AZITHROMYCIN : 500 MG FILM COATED TABLETS 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others  Pharmacy: Estmated Costs	96372			nylactic, or d	liagnostic ir	njection (speci	ify substa	nce or drug	); subcutaneous	or	Co.Pay	10.0000
149902- 1021 1021 1022 10384- 207801- 1002 1002 1002 1003 1002 1003 1002 1003 1003	4h3h5			on, for thera	py, prophy	laxis, or diagn	osis (spec	ify substan	ce or drug); initi	al,	Co.Pay	40.0000
Potassium Chloride: N/A) (SODIUM Chloride: N/A) (SODIUM LACTATE: N/A) SOLUTION   Pharmacy   5.000	149902-										6.5000	
100618- 1001 PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.400 86141 C-reactive protein; high sensitivity (hsCRP) Lab 30.00 85025 Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count  Code Generic Duration Instructions  0248-106304- 0271 (ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS  0013-127405- 0391 (AZITHROMYCIN : 500 MG FILM COATED TABLETS 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others  Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs  Surgery: Estmated Costs  Surgery: Endoscopy:  Surgery: Other Procedures:  If yes please specify  Indicate Provider Estimate Cost to release any informaton regarding my medical condition and history to NEXTCAL for the purpose of determining insurance benefts. Medical management is the schedical windicated & necessary for the management of his case.	0384- 207801- LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION Pharmacy 5.0000									5.0000		
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count    Code	2190- 106618- PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.4000											
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count   Duration Instructions  O248-106304- (ASCORBIC ACID (VITAMIN C): 1 G) EFFERVESCENT 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others  O13-127405- (AZITHROMYCIN: 500 MG FILM COATED TABLETS 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others  Pharmacy: Estmated Costs	86141	C-reactive protein; high sensitivity (hsCRP)  Lab  30.0000										
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O13-127405- 0391  (AZITHROMYCIN: 500 MG FILM COATED TABLETS  Description:  Surgery:  Physiotherapy:  Physiotherapy:  Indicate Provider  Indicate Provider  Estimate Cost  Indicate Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXICAL for the purpose of determining insurance benefits. Medical management is the soresponsibility of doctor and the patent.	Code	Ge	neric					Duration	Instructions			
Others    Califfront Coaled Tablets   State   Others									Day(s)			
Surgery:  Physiotherapy:  If yes please specify  Indicate Provider  Indicate Provider  Indicate Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXtCAI for the purpose of determining insurance benefits. Medical management is the solution of the patent.	$1\Delta/11$ HROMV(IN) 500 M(3 FILM) (10 $\Delta$ 1FI) 1 $\Delta$ 81F1 $\times$ 5											
So the following required  Other Procedures:  If yes please specify  Indicate Provider  Insurer, Employer or other Organizate  to release any informaton regarding my medical condition and history to NEXtCAI  for the purpose of determining insurance benefits. Medical management is the so  responsibility of doctor and the patent.	O Pharmacy: Estmated Costs O Laboratory / Radiology: Estmated Costs											
Sthe following required  Physiotherapy:  Other Procedures:  If yes please specify  Indicate Provider  Estimate Cost  Thereby certfy that all information mentioned are correct to that the medical services shown on this form were medically indicated & necessary for the management of his case.  Indicate Provider  Indicate Provider, Insurer, Employer or other Organizate to release any information regarding my medical condition and history to NEXtCAI for the purpose of determining insurance benefits. Medical management is the so responsibility of doctor and the patent.				Surgery	/:		OEndo	scopy:				
If yes please specify  Indicate Provider  Estimate Cost Indicate Provider  Indicate Provi												
hereby certfy that all informaton mentoned are correct that the medical services shown on this form were nedically indicated & necessary for the management of his case.  I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXtCAI for the purpose of determining insurance benefits. Medical management is the screen responsibility of doctor and the patent.	If yes please specify											
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	that the medic nedically indicat	cal service	es shown c	on this form	were	to release any for the purpo	y informa se of deta	iton regardi ermining ins	ng my medical c surance benefts.	condito	on and history to	NEXtCARE
reating Physician Name : <b>KEERTHANA</b>		n Name :	KEERTHA	NA				,				
el / Fax (important):	el / Fax (importa	int):										

Signature & Stamp	
د. کیرثانا رانی بادیبورایل ثارا Dr. Keerthana Rani Pradippurayil Thara General Practioner	
License No.: 37864046-001 مرکز سیتیکیر الطبی ذم م <u>CITICARE MEDICAL CENTER LLC</u> Date:	Patient's Signature(Parent if minor)  Date: 04-Aug-2025
Note: Claims must be submited along with supporting doc	

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