eASOAP FORM

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

Patent Name:	**MUHAMMAD SHUAIB TAJ MUHAMMAD**	Gender:	**Male**	Validity Between:	**22/04/2025 and 21/04/2026**
Card No:	**3E8B-E945-CB44-171E**	DOB:	**8/15/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-8526498-0**	Service Date:	**06-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0522460251**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47552**	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,urinary incontinence,dysuria ,weight loss HOPC low back pain,urinary incontinence,dysuria since 2 months.Low back pain more at night.Weight loss since 2 months O\E P\A SOFT NON TENDER No history of drug allergy			

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 : 130 T : 36.7 HR : 82 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	R30.0	Dysuria
Secondary	M54.5	Low back pain
Secondary	R32	Unspecified urinary incontinence

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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000

Code	Generic	Duration	Instructions
0003-282901-1171	(FLAVOXATE : 200 MG) TABLETS	3	Take 1Tablets 2 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 : 06-Aug-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		