# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **AYESHA YASEEN KHAIL UR REHMAN** | Gender: | **Female** | Validity Between: | **15/05/2025 and 14/05/2026** |
| Card No: | **ABD1-B01F-3CBA-E855** | DOB: | **6/5/1992 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1992-5098633-0** | Service Date: | **09-Aug-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **555298400** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **41881** | 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** | | |
|---|---|---|---|
| | DD | MM | YYYY |
| **Complaint**<br>pc :<br>ten times unilateral kind of headache. ASSOCIATED WITH DIZINESS , NAUSEA , AND FLICERING OF LIGHTS<br><br>o/e : look irritable<br>LETHARGIC | | | |

| **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 : 78 RR : 22 |
|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | R51.9 | Headache, unspecified |
| Secondary | R11.2 | Nausea with vomiting, unspecified |
| Secondary | K29.00 | Acute gastritis without bleeding |
| Secondary | H57.13 | Ocular pain, bilateral |

**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 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 5314-199803-1171 | (SUMATRIPTAN : 100 MG) TABLETS | 15 | Take 1Tablets 1 Time(s) per Day For 15 Day(s) after meal |
| 0188-130103-0392 | (PROPRANOLOL HCL : 10 MG) FILM COATED TABLETS | 10 | Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal |
| 2654-636101-0061 | (STARFLOWER OIL : 100 MG) (EVENING PRIMROSE OIL : 100 MG) (VITAMIN D3 : 5 MCG) (VITAMIN E : 30 MG) (VITAMIN C : 60 MG) (THIAMINE (VITAMIN B1) : 10 MG) (RIBOFLAVINE (VITAMIN B2) : 5 MG) (NIACIN : 36 MG) (VITAMIN B6 : 10 MG) (FOLACIN : 400 MCG) (VITAMIN B12 : 20 MCG) (BIOTIN : 50 MCG) (PANTOTHENIC ACID : 6 MG) (VITAMIN K : 90 MCG) (NATURAL MIXED CAROTENOIDS : 2 MG) (IRON : 12 MG) (MAGNESIUM : 100 MG) (ZINC : 12 MG) (MANGANESE : 2.5 MG) (COPPER : 1.5 MG) (SELENIUM : 100 MCG) (CHROMIUM : 50 MCG) (PA | 30 | Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal |
| 2104-379202-1451 | (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN) | 10 | Take 1Tablets 1 Time(s) per Day For 10 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 : **DR Amaizah** | | |
| Tel / Fax (important): | | |

| | |
|---|---|
| *Signature & Stamp*<br>Dr. Amaizah Ishtiaq<br>General Practitioner<br>DHA: 98486553-001<br>CITICARE MEDICAL CENTER<br>DUBAI - U.A.E | ***Patient's Signature(Parent if minor)*** |
| Date : | Date : 09-Aug-2025 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |