eASOAP FORM

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

Patent Name:	**RON JACOB EVANGELISTA AURIGUE**	Gender:	**Male**	Validity Between:	**02/07/2025 and 01/07/2026**
Card No:	**BE12-6511-A012-128A**	DOB:	**1/16/2025 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2025-9754398-6**	Service Date:	**12-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0561902116**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47359**	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
No Complaints Found for Selected Appointment					
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 : T : HR : RR :

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	L20.83	Infantile (acute) (chronic) eczema
Secondary	T78.40XA	Allergy, unspecified, initial encounter

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:		

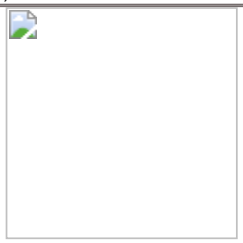
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400

Code	Generic	Duration	Instructions
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	7	Take 1.5ML 2 Time(s) per Day For 7 Day(s) before meal
0005-297810-0151	(HYDROCORTISONE : 1 G/100G) CREAM	7	Take 1Cream 2 Time(s) per Day For 7 Day(s) others
0244-567201-0571	(ARGININE : 0.50% W/W) (ALLANTOIN : 0.20% W/W) (PANTHENOL : 0.20% W/W) (GLYCERIN : 10% W/W) (NIACIN (VITAMIN B3; NICOTINIC ACID) : 0.50% W/W) (SHEA BUTTER : 2% W/W) (SODIUM PYRROLIDONE CARBOXYLIC ACID : 0.50% W/W) (HYDROXYPALMITOYL SPHINGANINE : 0.01% W/W) LOTION	30	Take 1Lotion 4 Time(s) per Day For 30 Day(s) others
0244-566901-0402	(ARGININE : 0.10% W/W) (ALLANTOIN : 0.20% W/W) (GLYCERIN : 5% W/W) (NIACIN (VITAMIN B3; NICOTINIC ACID) : 0.50% W/W) (SHEA BUTTER : 10% W/W) (SODIUM PYRROLIDONE CARBOXYLIC ACID : 0.50% W/W) FOAM	30	Take 1Shampoo 1Time(s) perDay For 30 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 Bushra**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 12-Aug-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		