eASOAP FORM

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

Patent Name:	**ATIQUR RAHMAN**	Gender:	**Male**	Validity Between:	**01/11/2024 and**
Card No:	**9A1A-3726-D980-3893**	DOB:	**7/20/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1982-0354298-4**	Service Date:	**22-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0568798553**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43018**	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 Sympton**	
Complaint	DD	MM
pc : shortness of breath and palpitations and chest tightness started 10/08/25 loss of appetite and bloating started 02 /08/25 serum urea elevated known diabetic and know htn o/e : look pale and lethargic tachycardia		

Past Medical Surgical History?	◯ Yes	◯ No	**Date of Sympton**	
			DD	MM

Obs/Gyn Claims						**Date of Sympton**	
						DD	MM
☐ 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 : 120 T : 36.3 HR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R00.2	Palpitations
Secondary	R06.00	Dyspnea, unspecified
Secondary	R30.0	Dysuria
Secondary	R35.8	Other polyuria
Secondary	I10	Essential (primary) hypertension
Secondary	E11.65	Type 2 diabetes mellitus with hyperglycemia

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/illn
○ 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
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Radiology

Code	Generic	Duration	Instructions
No Prescriptions History Found			

○ 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
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 ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefts. Medical manage responsibility of doctor and the patent.*
Treating Physician Name : **DR Amaizah**	
Tel / Fax (important):	

Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)***
Date :	Date : 22-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully rev
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doctors.