eASOAP FORM

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

Patent Name:	**HAREEM AKHTAR MALIK PERVEZ AKHTAR**	Gender:	**Female**	Validity Between:	**02/07/2025 and 21/12/2025**
Card No:	**EDA9-96E7-BC3B-71B1**	DOB:	**1/31/2001 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2001-6605592-9**	Service Date:	**23-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0563949253**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47689**	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 SHIVERING,BREATHING DIFFICULTY,TIREDNESS,CHEST PAIN HOPC PT PRESENTS WITH COMPLAINTS OF SUDDEN ONSET SHIVERING,BREATHING DIFFICULTY,CHEST PAIN,TIREDNESS THAAT STARTED AT AROUND 1.30AM Pt had similar episode 5 months back She denies any food allergy O\E she looks pale,irritated SpO2 99% Chest clear Pulse regular Conscious oriented She had chicken curry for the dinner at around 8 pm			

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 : 36.6 HR : 88 RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R68.83	Chills (without fever)
Secondary	R06.00	Dyspnea, unspecified
Secondary	R25.1	Tremor, unspecified
Secondary	R11.0	Nausea
Secondary	R07.9	Chest pain, unspecified

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
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0384-111908-1001	SODIUM CHLORIDE BP	Pharmacy	4.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400

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	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 : 23-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	