eASOAP FORM

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

Patent Name:	**RHEA LETIZIA JAIRIN**	Gender:	**Female**	Validity Between:	**13/06/2025 and 12/06/2026**
Card No:	**9B1E-3D3F-96FB-25F0**	DOB:	**7/9/2023 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2023-1168470-2**	Service Date:	**25-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0556811094**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47136**	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
2 years old girl with C/O: cough runny nose, flu , congestion fever duration: 5 days taking cefpodoxime since 3 days. vaccinated for her age brother is also having similar complaints of viral fever ongoing. birth normal, developmentally appropriate for her age Picky eater, fusses around food. on examination: hyperemic and congested throat with enlarged tonsillar pillars pale conjunctiva , pallor on hands, height and weight are on less than 5th percentile > needs evaluation of nutritional deficiencies. CNS: Intact CVS: Heart sounds normak chest: harsh vesicular breathing Abdomen: soft, non tender			

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 : 0 T : 37.1 HR : 102 RR : 22

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

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	E56.9	Vitamin deficiency, unspecified
Secondary	D64.9	Anemia, 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
9	GP Consultation	General Consultation	25.0000
82728	Ferritin	Lab	20.0000
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Lab	100.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0006-106607-1161	(PARACETAMOL : 240 MG/5ML) SYRUP	3	Take 3ML 2 Time(s) per Day For 3 Day(s) after meal, in case of fever
6396-925801-3851	(SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY	5	Take 3ML 4 Time(s) per Day For 5 Day(s) before meal
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	5	Take 5 Unit(s), 1 Time(s) per Day For 5 Day(s)

◯ 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  Dr. Bushra Mufti General practitioner DHA: 75646242-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 
Date :	Date : 25-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	