eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out Patient** at the **Irham Medical Ce**

Patent Name:	**SAMEERA ALI USMAN**	Gender:	**Female**	Validity Between:	**22/07/2023 and**
Card No:	**5B9B-0397-1368-6CC9**	DOB:	**10/1/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1995-1706506-8**	Service Date:	**25-May-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502295430**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40702**	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
Blood in urine, pain on passing urine, pain in the right flank and frequency on passing urine. Has a history of kidney stone on the same side. There is also low grade fever.		

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

Obs/Gyn Claims						**Date of Symptor**	
						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 : 98 T : 37.5 HR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	N10	Acute pyelonephritis

Type	Code	Diagnosis
Secondary	N30.01	Acute cystitis with hematuria
Secondary	N20.2	Calculus of kidney with calculus of ureter
Secondary	R50.9	Fever, 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/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
9	GP Consultation	General Consultati
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab

Code	Generic	Duration	Instructions
0005-106601-1171	(PARACETAMOL : 500 MG) TABLETS	3	Take 1Tablets 2 T For 3 Day(s) afte
5098-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	7	Take 1Tablets 2 T For 7 Day(s) afte
0053-111703-0251	(SODIUM CITRATE : 630 MG) (TARTARIC ACID : 890 MG) (SODIUM BICARBONATE : 1.75 G) (CITRIC ACID : 720 MG) EFFERVESCENT GRANULES	5	Take 1Powder 1 For 5 Day(s) afte
0054-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2T For 5 Day(s) afte

◯ 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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical manageme responsibility of doctor and the patent.*
Treating Physician Name : **Enomen Goodluck**	
Tel / Fax (important):	

Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)*** 
Date :	Date : 25-May-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	