eASOAP FORM

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

Patent Name:	**WAHYU TRISNANINGTIAS**	Gender:	**Female**	Validity Between:	**04/06/2024 and 03/06/2025**
Card No:	**A71B-11A9-8F89-8206**	DOB:	**3/13/1988 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1988-9560089-2**	Service Date:	**18-Jul-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0547782988**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43519**	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: stomach ache 5 days flank pain burning micturation bloating 1 day fever uti diarrhea			

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 : 102 T : 36.5 HR : 92 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	R30.9	Painful micturition, unspecified
Secondary	R19.7	Diarrhea, unspecified

Type	Code	Diagnosis
Secondary	R10.13	Epigastric pain
Secondary	R14.1	Gas pain

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
81003	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, without microscopy	Lab	8.0000
2040-106618-1001	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
0005-174202-0781	RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION	Pharmacy	34.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-107704-0801	Triaxone (Ceftriaxone [1 G]) Powder For Injection (1 + 3.5ml, Vial + Solvent Ampoule)	Pharmacy	58.5000

Code	Generic	Duration	Instructions
5098-482002-0391	(CIPROFLOXACIN (AS HYDROCHLORIDE) : 250 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0248-187801-1171	(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0707-559701-0971	(ARGININE : 17 MG) (BETACAROTENE : 3.3 MG) (RIBOFLAVINE (VITAMIN B2) : 530 MCG) (TAURINE : 17 MG) (NICOTINAMIDE : 6 MG) (THIAMINE (VITAMIN B1) : 470 MCG) (ASCORBIC ACID (VITAMIN C) : 20 MG) (VITAMIN E : 3.3 MG) (LUTEIN : 5MG) (CHROMIUM (AS CHROMIUM PICOLINATE) : 16.7 MCG) (ZEAXANTHIN : 40 MCG) (SELENIUM YEAST : 18.33 MCG) (ZINC (AS ZINC DIOXIDE) : 4 MG) (MAGNESIUM CITRATE : 3.7 MG) (CALCIUM CITRATE : 5.3 MG) (CRANBERRY : 33.3 MG) SOFT GELATIN CAPSULES	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
1641-500401-1171	(BETAINE : 100 MG) (OX BILE EXTRACT : 40 MG) (PEPSIN : 100 MG) (PANCREATIN : 50 MG) (AMYLASE : 50 MG) (LIPASE : 15 MG) (BROMELAIN : 50 MG) (PAPAIN : 50 MG) (DICALCIUM PHOSPHATE : 54 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal

◯ 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 : **Enomen Goodluck**		

Tel / Fax (important):	
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 18-Jul-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	