

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MUHAMMAD HAMZA MUHAMMAD JAVED	Gender:	Male	Validity Between:	18/07/2024 and 17/07/2025
Card No:	C747-C9F1-7105-774F	DOB:	10/6/1995 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)- MEDGULF
Natonal ID:	784-1995-1921703-0	Service Date:	27-Jul-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0568653986		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	38208	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 PC: Upper abdominal pain, nausea and diarrhea. Has a history of gastritis. There is no fever.						DD	MM	YYYY
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 : 134 T : 36.9 HR : 74 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K29.00	Acute gastritis without bleeding					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	E86.0	Dehydration					
Secondary	R10.9	Unspecified abdominal 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
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
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
86677	Antibody; Helicobacter pylori	Lab	25.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0102-152902-1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION	Pharmacy	5.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000

Code	Generic	Duration	Instructions
0415-200001-1452	(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	1	Take 2Capsule 1Time(s) perDay For 1 Day(s) others
0042-136501-1173	(HYOSCINE : 10 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0005-141604-0081	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	5	Take 1Tablets 6Time(s) perDay For 5 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) before meal

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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> Treating Physician Name : Enomen Goodluck Tel / Fax (important): Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. <i>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i> Patient's Signature(Parent if minor)		
Date : Date : 27-Jul-2024		

Note: Claims must be submitted along with supporting documents within 30 days from date of service

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