eASOAP FORM

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

Patent Name:	**Chaltu Kero Megerso**	Gender:	**Female**	Validity Between:	**09/02/2024 and (**
Card No:	**CF4E-7009-5FC6-9D2B**	DOB:	**9/16/1989 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1989-7143729-2**	Service Date:	**28-Aug-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0568702869**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43961**	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 Symptom**	
Complaint	DD	MM
PC: Chest pain and palpitation started this morning. This is the first episode in patient's life. Pain is said to radiate to both arms and is more serious during exertion, there was also sweating this morning when it started but has subsided. Pain did not persist till presentation. CVS exam: PR = 56b/m, regular small volume, BP as documented, no murmurs., HS=1,2 only Abdomen: mild epigastric tenderness.		

Past Medical Surgical History?	○ Yes	○ No	**Date of Symptom** DD	MM

Obs/Gyn Claims						Date of Symptom	
						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 : 96 T : 36.9 HR : RR : 20

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

Type	Code	Diagnosis
Primary	I21.9	Acute myocardial infarction, unspecified
Secondary	I20.9	Angina pectoris, unspecified
Secondary	R07.9	Chest pain, unspecified
Secondary	R00.2	Palpitations
Secondary	K29.00	Acute gastritis without bleeding

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/illne
○ 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

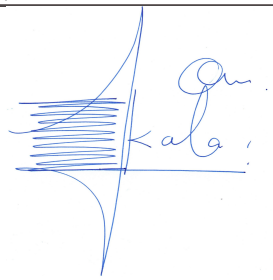
CPT Code	Treatment	Type
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay
0005-174202-0781	RISEK 40MG	Pharmacy
83009	Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (eg, C-13)	Lab
86677	Antibody; Helicobacter pylori	Lab
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab
86140	C-reactive protein;	Lab
84484	Troponin, quantitative	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab
9	GP Consultation	General Consultati
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay

Code	Generic	Duration	Instructions

Code	Generic	Duration	Instructions
0006-106601-0394	(PARACETAMOL : 500 MG) FILM COATED TABLETS	4	Take 2Tablets 3 Time(s Day(s) after meal
0005-141604-0081	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	5	Take 1Tablets 6 Time(s Day(s) after meal
0096-124202-1171	(ASPIRIN : 75 MG) TABLETS	30	take 4 tablet (300mg) then 1 (75mg) tablet e
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	14	Take 1Tablets 2Time(s Day(s) before 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
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 managemer responsibility of doctor and the patent.*
Treating Physician Name : **Enomen Goodluck**	
Tel / Fax (important):	
 *Signature & Stamp* 	***Patient's Signature(Parent if minor)*** 
Date :	Date : 28-Aug-2024

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

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.