eASOAP FORM

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

Patent Name:	**NIWANKA PRIYANTHI TENNAKOON**	Gender:	**Female**	Validity Between:	**03/04/2024 and 0**
Card No:	**6F73-F9F8-28F9-CA73**	DOB:	**7/4/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1987-5565538-2**	Service Date:	**02-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0553485917**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44000**	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: Dizziness of sudden onset, left side. There's associated buzzing sound in the left ear and headache. Not hypertensive and not diabetic and has no other medical condition in the past.		

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 : 130 T : 36.5 HR : RR : 18

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

Type	Code	Diagnosis
Primary	H81.12	Benign paroxysmal vertigo, left ear
Secondary	H93.12	Tinnitus, left ear
Secondary	R51.9	Headache, 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/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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy
9	GP Consultation	General Consultation

Code	Generic	Duration	Instructions
5353-840001-1172	(CINNARIZINE : 20 MG) (DIMENHYDRINATE : 40 MG) TABLETS	5	Take 1Tablets 3 Time(s) per Dav others
1394-380701-1171	(BETAHISTINE HCL : 16 MG) TABLETS	3	Take 1Tablets 3 Time(s) per Dav others

○ 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 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 : 02-Sep-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
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no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N
doctors.