

eASOAP FORM

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

Patent Name:	WINROSE PASULA USARAGA	Gender:	Female	Validity Between:	28/11/2023 and 2
Card No:	AE0D-96B0-F036-931B	DOB:	3/2/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansa MEDGULF
Natonal ID:	784-1988-2482732-7	Service Date:	18-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0585994214		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41681	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 co bloating nausea headache pallor 12th sep . 2024 she is taking medicine ferros sulphate Imp 24 th august 2024 oe epigastric pain chest is clear no added sounds restless						DD	MM
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 : 99 RR : 18	T : 37.3	HR :
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	E86.0	Dehydration
Secondary	R11.0	Nausea

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

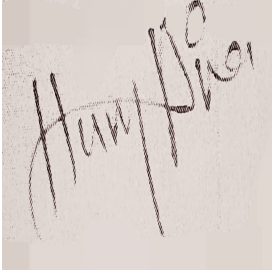
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occurred
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay
83550	Iron binding capacity	Lab
84466	Transferrin	Lab
83540	Iron	Lab
86677	Antibody; Helicobacter pylori	Lab
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay
0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION	Pharmacy
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy
9	GP Consultation	General Consultation

Code	Generic	Duration	Instructions
0097-230603-0832	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet : For 5 Day(s) o
0270-189301-0082	(ALUMINIUM HYDROXIDE : N/A) (SODIUM BICARBONATE : N/A) (ALGINIC ACID : N/A) (MAGNESIUM TRISILICATE : N/A) CHEWABLE TABLETS	7	Take 1Tablets Day For 7 Day
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets Day For 7 Day

☐ 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	
<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>		<i>I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>	
Treating Physician Name : Humaira			
Tel / Fax (important):			
Signature & Stamp  		 Patient's Signature(Parent if minor)	
Date :		Date : 18-Sep-2024	
Note: Claims must be submitted 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 effects 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.