eASOAP FORM

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

Patent Name:	**YOSSRA BEN SLIMENE**	Gender:	**Female**	Validity Between:	**13/07/2024 and 1**
Card No:	**4C9C-CC5D-F031-D1D4**	DOB:	**5/3/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1987-1080708-6**	Service Date:	**26-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**971561771000**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI NATIONAL INSURANCE AND REINSURANCE CO**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41330**	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
co fever on and off running nose productive cough bad order from mouth 21st sep. 2024 oe tonsills enlarge chest is congested no added sounds restless smoker		

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 T : 36.7 HR : RR : 18

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

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R05	Cough
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R50.9	Fever, 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

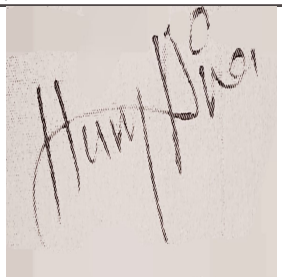
CPT Code	Treatment	Type
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
9	GP Consultation	General Consultation
9	GP Consultation	General Consultation
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR	1	Take 10ML 3 Time(s) per Day F

Code	Generic	Duration	Instructions
	FREE)		meal
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Tablets 2 Time(s) per Da others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Da others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Da 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 : **Humaira**	
Tel / Fax (important):	
Signature & Stamp  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 26-Sep-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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