eASOAP FORM

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

Patent Name:	**ASHA THATTASSERIL PADMAVATHY NEELAKANDAN**	Gender:	**Female**	Validity Between:	**25/11/2023 and 24/11/2024**
Card No:	**7504-3D2B-B81F-852B**	DOB:	**5/25/1978 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1978-7310218-6**	Service Date:	**29-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0564999790**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37217**	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	DD	MM	YYYY
PC: Fever, headache, and photophobia. Also has neck pain but no neck stiffness. Also white vaginal discharge, itching and painful micturition. Duration: 2days (26/09/2024). Also has a history of multiple hydradenitis suppuretiva and has been referred on several occasion to the general surgeon but declined.			

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 : 122	T : 38.1	HR : 96	RR : 20

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

Type	Code	Diagnosis
Primary	L73.2	Hidradenitis suppurativa
Secondary	L03.311	Cellulitis of abdominal wall
Secondary	L02.211	Cutaneous abscess of abdominal wall
Secondary	R50.9	Fever, unspecified
Secondary	G43.919	Migraine, unsp, intractable, without status migrainosus
Secondary	K29.00	Acute gastritis without bleeding
Secondary	N39.0	Urinary tract infection, site not specified
Secondary	N77.1	Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr
Secondary	B37.41	Candidal cystitis and urethritis

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
9	GP Consultation	General Consultation	25.0000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
0252-140201-0061	(FLUCONAZOLE : 150 MG) CAPSULES	1	Take 1Tablets 1 Time(s) per Day For 1 Day(s) others, the repeat after one week
0005-106601-0052	(PARACETAMOL : 500 MG) CAPLETS	4	Take 2Tablets 3 Time(s) per Day For 4 Day(s) after meal
0188-232401-0391	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) before meal
1395-397601-0391	(SUMATRIPTAN (AS SUCCINATE) : 100 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0067-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) after 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	Estimate Cost
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 other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole 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 : 29-Sep-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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