

eASOAP FORM


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

Patent Name:	DAINA MUENI MUENDO	Gender:	Female	Validity Between:	26/02/2024 and 08/02/2025
Card No:	B648-1D82-60F9-E7E5	DOB:	10/31/1997 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1997-7423352-4	Service Date:	09-Oct-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0523836819		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44455	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		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
co fever on and off headache and abdominal pain sep 2024 from one month oe epigastric pain chest is clear no added sounds restless							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					DD	MM	YYYY
Obs/Gyn Claims					Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:					DD	MM	YYYY
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 : 108 : 18	T : 36.6	HR : 72	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R50.9	Fever, unspecified
Secondary	R10.13	Epigastric pain
Secondary	E86.0	Dehydration

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:		

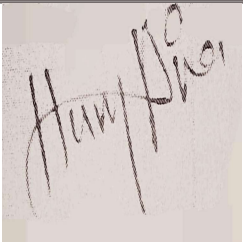
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
9	GP Consultation	General Consultation	25.0000
0102-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
87338	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool	Lab	30.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0270-189301-0081	(ALUMINIUM HYDROXIDE : N/A) (SODIUM BICARBONATE : N/A) (ALGINIC ACID : N/A) (MAGNESIUM TRISILICATE : N/A) CHEWABLE TABLETS	14	Take 1Tablets 3 Time(s) per Day For 14 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) others
0195-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0195-148602-0361	(CLARITHROMYCIN : 500 MG) EXTENDED RELEASE TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others

☐ 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	Estimate Cost
I hereby certify that all informaton mentoned are correct & that the medical services shown on this form were		I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE

medically indicated & necessary for the management of this case.	for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.
Treating Physician Name : Humaira	
Tel / Fax (important):	
 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 09-Oct-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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