eASOAP FORM

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

Patent Name:	**Saleh Abdelmonsef Fawy Darder**	Gender:	**Male**	Validity Between:	**01/01/2024 and**
Card No:	**09FB-071A-43C1-CCE5**	DOB:	**12/28/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1982-8258539-1**	Service Date:	**29-Oct-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0562600065**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42851**	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**	
	DD	MM
Complaint Generalized abdominal pain, worst at the epigastrum, fever, and cough Duration: 5days (21/10/24) Cough is productive of thick cream sputum Also has headache (claims is migraine as he has a previous and recurrent history of migraine). Exam: scaly scalp with large area of central clearing and active margin (dandruff).		

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 : 114 T : 37.8 HR : RR : 18

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

Type	Code	Diagnosis
Primary	J22	Unspecified acute lower respiratory infection
Secondary	R05	Cough
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
Secondary	K59.00	Constipation, unspecified
Secondary	K58.1	Irritable bowel syndrome with constipation
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	Price
9	GP Consultation	General Consultation	25.0

Code	Generic	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	10	Take 10ML 3 Time(s) per D after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	10	Take 1Tablets 2 Time(s) pe Day(s) after meal
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) pe Day(s) after meal
1654-525701-1091	(CHARCOAL, ACTIVATED : 250 MG) (SIMETHICONE : 80 MG) SUGAR-COATED TAB	30	Take 1Tablets 3 Time(s) pe Day(s) after meal
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	15	Take 1Tablets 2 Time(s) pe Day(s) after meal
0027-109206-0151	(TERBINAFINE (AS HCL : 1% CREAM	30	Take 1Cream 2 Time(s) per Day(s) others
0027-109204-1171	(TERBINAFINE (AS HCL) : 250 MG) TABLETS	14	Take 1Tablets 2 Time(s) pe Day(s) others
0006-199803-1171	(SUMATRIPTAN : 100 MG) TABLETS	14	Take 1Tablets 1 Time(s) pe Day(s) 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 : 29-Oct-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 will not be held responsible for misuse of claims submission's or any adverse efects 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.