

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: BASALAT ALI	Gender: Male	Validity Between: 09/10/2024 and 08/10/2025
Card No: CEA6-D8E3-B6ED-B035	DOB: 6/1/1999 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1999-3186428-6	Service Date: 03-Nov-2024	Radiology: Covered
Policy Holder:	Patent's Tel No: 0527886321	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent :	
Gatekeeper: No	Patent's File No: 44793	Pharmacy: Co-Part: 20%
Referral No:	Consultaton :	Laboratory: Covered
Referred Service:		

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: H PYLORI POSITIVE								
TAKING ORAL TREATMENT								
SVERE ABDOMINAL PAIN								
NAUSEA								
VOMITING								
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 : 105 T : 37 HR : 79 RR : 19			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K29.00	Acute gastritis without bleeding					
Secondary	B96.81	Helicobacter pylori as the cause of diseases classd elswhr					
Secondary	R10.13	Epigastric pain					
Secondary	R11.2	Nausea with vomiting, 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/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		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
9	GP Consultation	General Consultation	25.0000		
0005-149902-1021	CLOFEN	Pharmacy	6.5000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
0005-136504-1021	SCOPINAL	Pharmacy	4.6000		
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000		
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000		
Code	Generic	Duration	Instructions		
0152-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) after meal		
0135-116411-1171	(AMOXICILLIN : 1 G) TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) after meal		
0195-148602-0362	(CLARITHROMYCIN : 500 MG EXTENDED RELEASE TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 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 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 benefsts. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : AHSAN HUSSAIN					
Tel / Fax (important):					
 Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		 Patient's Signature(Parent if minor)			
Date :		Date : 03-Nov-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 creaton 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

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