eASOAP FORM

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

Patent Name:	**MAH AFROZE AHMED MEMON**	Gender:	**Female**	Validity Between:	**24/09/2024 and**
Card No:	**117A-2FC1-05EA-AB35**	DOB:	**9/15/1991 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1991-0915037-7**	Service Date:	**15-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0585867834**		
Policy Holder:		Threshold Limit:			
Payer Name:	**TAKAFUL EMARAT**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44912**	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 Sympton**	
Complaint	DD	MM
pc: nausea with vomiting 1 day 13/11/2024 headache low back ache allergic dermatitis cyst at feet 2 days		

Past Medical Surgical History?	○ Yes	○ No	**Date of Sympton**	
			DD	MM

Obs/Gyn Claims						**Date of Sympton**	
						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 : 110 T : 36.6 HR : 18

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

Type	Code	Diagnosis
Primary	R11.2	Nausea with vomiting, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R51.9	Headache, unspecified
Secondary	M54.5	Low back pain
Secondary	L23.9	Allergic contact dermatitis, unspecified cause
Secondary	L72.0	Epidermal cyst

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/illn
◯ 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
9	GP Consultation	General Consultatior
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab
82785	Gammaglobulin (immunoglobulin); IgE	Lab
0005-174202-0781	RISEK 40MG	Pharmacy
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy

Code	Generic	Duration	Instructions
1291-380702-1171	(BETAHISTINE HCL : 8 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For
0005-150407-1172	(METOCLOPRAMIDE : 10 MG TABLETS	7	Take 1Tablets 2 Time(s) per Day For
1797-119809-1171	(PREDNISOLONE : 1 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For

◯ 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 ot to release any informaton regarding my medical conditon and histo for the purpose of determining insurance benefts. Medical manage 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 : 15-Nov-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
responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX
doctors.