eASOAP FORM

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

Patent Name:	**NOELY ISABEL BRITO CRUZETA**	Gender:	**Female**	Validity Between:	**23/02/2024 and 31/12/2024**
Card No:	**8C04-F24A-304D-41CA**	DOB:	**4/18/1999 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1999-8996157-0**	Service Date:	**15-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0506449809**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MetLife**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44919**	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**		
	DD	MM	YYYY
Complaint PC: Feeling of recurrent anxiety, palpitations, tremors and headache, also nausea and vomiting. Headache is located at the temporal region and has aural as she feels faint prior to the onset of headaches. She is not hypertenisve and not diabetic and has no past medical conditions. Has past history of depression and anxiety disorder for which she was placed on medications for sometime. Said to have been thinking alot due to pressure at work and has had the need to think about suicide, but there is no hallucinations and no delusions.			

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 : 110 T : 36.6 HR : 88 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	F41.9	Anxiety disorder, unspecified
Secondary	F41.0	Panic disorder [episodic paroxysmal anxiety]

Type	Code	Diagnosis
Secondary	G43.109	Migraine with aura, not intractable, w/o status migrainosus
Secondary	K29.70	Gastritis, unspecified, without bleeding
Secondary	R00.2	Palpitations

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
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
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	4	Take 2Tablets 3 Time(s) per Day For 4 Day(s) after meal
0005-141604-0081	(ALUMINIUM HYDROXIDE : 200 MG (MAGNESIUM HYDROXIDE : 200 MG (SIMETHICONE : 25 MG CHEWABLE TABLETS	7	Take 1Tablets 4 Time(s) per Day For 7 Day(s) others
0188-232402-0391	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0006-199803-1171	(SUMATRIPTAN : 100 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 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 : 15-Nov-2024	

Note: Claims must be submited along with supportng documents within 30 days from date of service