## **eASOAP FORM**



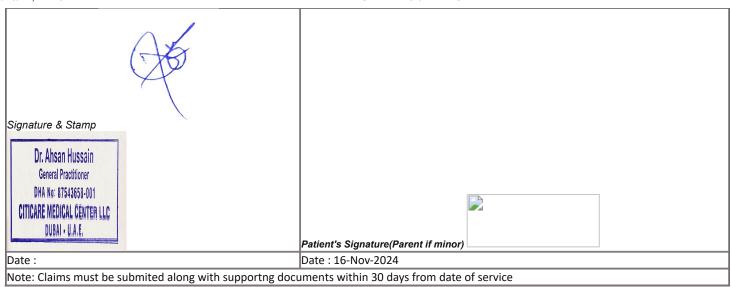
ADMINISTRATIV	E The n	nember is allowed	for <b>Out Patient</b>	at the CITICARE MEDICAL CENTER LLC			
Patent Name:	PUTU SURYA CAPRIONITA	Gender:	Female	Validity Between:	30/06/2	024 and 29/0	6/2025
Card No:	BA0B-6B27-53AD-83DA	DOB:	12/22/1998 12:00:00 AM	Coverage Informaton for:	Out Pa	tient	
Pin #:		Identty Card:		Network:	RN UA	E (Al Ansari- <i>i</i> ULF	AUH)-
Natonal ID:	784-1998-2207239-5	Service Date:	16-Nov-2024	Radiology:	Covere	d	
		Patent's Tel No:	0521699659				
Policy Holder:		Threshold Limit:					
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal				
		Out-Patent :					
Category:	Category B	Patent's File No:	39191	Pharmacy:	Co-Par	t: <b>20</b> %	
Gatekeeper:	No	Consultaton :		Laboratory:	Covere	d	
Referral No:							
Referred							
Service:							
SUBJECTIVE ASS	ESSMENT						
Symptom(s) as described by the patent (Chief Complaint):						Symptoms/ill	ness started
Complaint						MM	YYYY
					1		

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started				
Complaint							DD	ММ	YYYY	
PC: Severe headache, nausea, vomiting (2episodes) and dizziness.										
Headache is	located on the right	temporal reg	gion/							
Duration: 5days.										
Past Medical Surgical History?							Date of Symptoms/illness started			
r ast ivicalcars				0 163				DD	ММ	YYYY
								Date of S	 Symptoms/i	liness started
Obs/Gyn Clain	ns						H		MM	YYYY
Para	Gravida:	□ АВ:	: LMP: Marital Status: Marital Date:							
What date did t	he Patient first feel sa	l me / similar S	l Symptom(s)	l ) : dd mm yyy	У	l				
Is the Patient u	nder any type of Treat	ment? OYe	s O No	if yes, indica	te what Asses	ssment and since	when:			
OBJECTIVE / A	ASSESSMENT(To be	completed by	Physician)							
Clinical Findings: Vital Signs: B/P:100 T:36						5.5	HR : 86	RR		
Assessment/D	Diagnosis : O Ac DICATE DIAGNOSIS		Chronic OM	O Confirm	ed OSusp	ected				
Туре	Code	Diag	nosis							
Primary	G43.119	Migr	Migraine with aura, intractable, without status migrainosus							
Secondary	R11.10	Vom	Vomiting, unspecified							

Туре	Code	Diagnosis
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
Secondary	M62.830	Muscle spasm of back
Secondary	M54.5	Low back pain

Secondary	M54.5 Low back pain									
ACCIDENT/OCCUP	ATIONAL Claim I	nformaton	(complete i	f claim is a res	sult of accider	nt or work related illn	ess/injury)			
Accident or illness	due to work?		Injury due accident?	to road	Describe how the accident or work related injury/illness occur:					
○ Yes ○ No			○Yes ○	No						
Date of accident o	r beginning of illr	ness:								
MEDICAL PLAN Ite	mized Original In	voices and	Applicable (	Prescriptions /	Reports / Res	sults must be enclosed	d to consider claim			
CPT Code	Treatment						Туре	Price		
9.01	Follow-up consultation  General Consultation  0.0									
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour  Co.Pay									
2190-106618- 1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.4000									
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular									
0005-150403- 1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION Pharmacy							0.9000		
Code	Code Generic Duration Instructions									
1217-373201- 2401	(TOLPERISO TABLETS	NE : 150 M	G) SUGAR C	OATED	7	Take 1Tablets 2 Tim meal	olets 2 Time(s) per Day For 7 Day(s) after			
0005-150407- 1173	.0 MG TABL	ETS	7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) af meal			y(s) after				
O Pharmacy:	Costs	Costs Caboratory / R.			Estmated Costs					
	y: (		O Endoscopy:							
Is the following required		OPhysio	therapy:		Other Procedures:		1			
			If yes please s	specify	1					
Is In-patient Required ? Length of Stay Indicate Provider Estimate Cost										
I hereby certfy tha			are correct	I hereby auth		aer Ithcare Provider, Insur				
& that the medical	services shown o	on this form	were		•	egarding my medical		-		
		41		C + L			. A A1: 1			

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost		
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Employ	er or other Organizaton		
& that the medical services shown on this form were	to release any informaton regarding my medical conditon and history to NEXtC			
medically indicated & necessary for the management of	for the purpose of determining insurance benefts. Medical management is t			
this case.	responsibility of doctor and the patent.			
Treating Physician Name : AHSAN HUSSAIN				
Tel / Fax (important):				



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