

eASOAP FORM


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

Patent Name:	MICHELLE BANDILLA DIMERO	Gender:	Female	Validity Between:	14/03/2024 and 13/03/2025
Card No:	DD86-FBEC-596A-35EE	DOB:	12/11/1982 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1982-1806180-6	Service Date:	17-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0521823424		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44929	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: Vomit, headache, and weakness. Duration: 2days (16/11/2024)						DD	MM	YYYY
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 : 36.5	HR : 86	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R11.10	Vomiting, unspecified					
Secondary	R42	Dizziness and giddiness					
Secondary	R53.1	Weakness					
Secondary	A09	Infectious gastroenteritis and colitis, unspecified					

Type	Code	Diagnosis
Secondary	E86.0	Dehydration

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:		

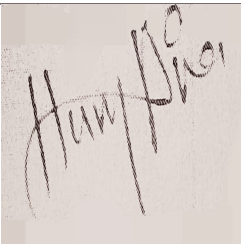
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0102-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	3	Take 1Tablet as per need
0005-150407-1172	(METOCLOPRAMIDE : 10 MG TABLETS	3	Take 1Tablet as per need
0325-142902-1171	(CEFIXIME : 400 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 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 benefets. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : Humaira		
Tel / Fax (important):		

 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 Patient's Signature(Parent if minor)
Date :	Date : 17-Nov-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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