

eASOAP FORM


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

Patent Name:	CAROLINE NALUKWAGO	Gender:	Female	Validity Between:	16/10/2024 and 08/02/2025
Card No:	6C89-D8EE-3261-0BB8	DOB:	12/28/1996 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1996-1575011-6	Service Date:	17-Nov-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0528421087		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44932	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
co headache pain in throat 13th nov. 2024								
oe chest is clear no added sounds								
restless								
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:								

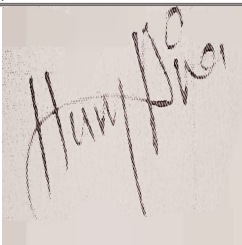
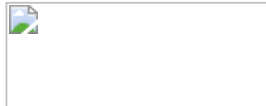
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :				Vital Signs : B/P : 90 T : 36 HR : 86 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	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:
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☐ 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
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0102-111908-1001	SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION	Pharmacy	4.5000
Code	Generic	Duration	Instructions
7020-992601-1171	(VITAMIN D (AS CHOLECALCIFEROL) : 5 MCG) (CHROMIUM : 25 MCG) (VITAMIN A (AS BETA CAROTENE) : 1200 MCG) (VITAMIN E : 4.5 MG) (BIOTIN : 30 MCG) (VITAMIN C (ASCORBIC ACID) : 45 MG) (RIBOFLAVIN : 1 MG) (MANGANESE : 1.8 MG) (VITAMIN B6 : 1.3 MG) (NIACINAMIDE : 14 MG) (SELENIUM : 20 MCG) (FOLIC ACID : 240 MCG) (MAGNESIUM : 100 MG) (IRON : 10 MG) (VITAMIN B12 : 2.4 MCG) (CALCIUM : 320 MG) (PANTOTHENIC ACID : 5 MG) (THIAMINE : 1 MG) (COPPER : 0.45 MG) (ZINC : 7 MG) (IODINE : 33 MCG) (VITAMIN K1 : 25 MC	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) others
0097-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others
☐ 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 : 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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