

eASOAP FORM

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

Patent Name:	SAMANA K C	Gender:	Female	Validity Between:	17/10/2024 and 17/10/2025
Card No:	7459-2E6F-4FB2-2AF5	DOB:	1/17/1989 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ans: MEDGULF)
National ID:	784-1989-0364295-1	Service Date:	19-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0589470450		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44951	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 Symptom	
Complaint						DD	MM
co epigastric pain pallor pain in joints 12th nov . 2024							
oe							
chest is clear no added sounds							
restless							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						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 RR : 18	T : 36.5	HR :
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R10.13	Epigastric pain
Secondary	M25.40	Effusion, unspecified joint
Secondary	D64.9	Anemia, unspecified
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 occurred
☐ 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
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay
9	GP Consultation	General Consultation
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0102-152902-1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION	Pharmacy
0005-136504-1021	SCOPINAL	Pharmacy
0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION	Pharmacy
84550	Uric acid; blood	Lab
83550	Iron binding capacity	Lab
83540	Iron	Lab
86677	Antibody; Helicobacter pylori	Lab

Code	Generic	Duration	Instructions
1267-141614-1111	(ALUMINIUM HYDROXIDE : 225 MG/5ML (SIMETHICONE : 25 MG/5 ML (MAGNESIUM HYDROXIDE : 200 MG/5ML SUSPENSION	1	Take 10ml after
0188-232402-0391	(ESOMEPRAZOLE : 20 MG FILM COATED TABLETS	7	Take 1Tablets 2 For 7 Day(s) of

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	

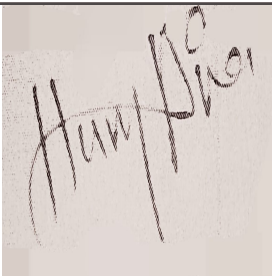
☐	Physiotherapy:	☐ Other Procedures:
		If yes please specify

Is In-patient Required ? Length of Stay	Indicate Provider
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<i>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>	<i>I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>
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Treating Physician Name : Humaira	
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Tel / Fax (important):	
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Signature & Stamp  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. 	
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Date :	Date : 19-Nov-2024
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Note: Claims must be submitted along with supporting documents within 30 days from date of service
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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: no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.