

eASOAP FORM

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

Patent Name:	Raghad Radwan Kanaan	Gender:	Female	Validity Between:	25/10/2024 and 2
Card No:	1B44-F86D-A1B2-068A	DOB:	1/3/1997 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansa MEDGULF
National ID:	784-1997-2849233-3	Service Date:	25-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0544465313		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	45017	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptom	
Complaint						DD	MM
PC: Upper abdominal pain, that radiates upwards to the chest associated with vomiting for which she has had over 3 episodes.							
There is associated cough as well.							
Duration: 3days (22/11/2024).							
Commenced self-prescribed medications including azithromycin today.							
PMHx: PCOS (on metformin)							
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 : 100	T : 38	HR :
	RR : 18		

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	N39.0	Urinary tract infection, site not specified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

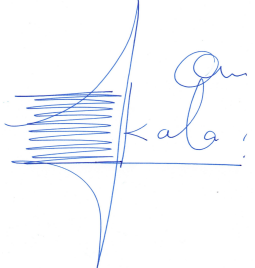
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occurred:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type
9	GP Consultation	General Consultative
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
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
2027-560101-0392	(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	5	Take 1Tablets 2 Tim 5 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS	10	Take 1Tablets 2Time 10 Day(s) after mea
0188-232402-0391	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Tim 7 Day(s) before mea
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Tim 10 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
<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>
Treating Physician Name : Enomen Goodluck	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 25-Nov-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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 effects 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.