

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	TAMARA KOBAISSI KOBALISSI	Gender:	Female	Validity Between:	30/03/2024 and 29/03/2025
Card No:	DF1A-C6C3-3C15-22EA	DOB:	12/31/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-7907286-9	Service Date:	30-Nov-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	000000000000		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45071	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
PC: Vomiting, diarrhea and vague lower abdominal pain.								
Duration: `1 day								
Said to have woken up with these symptoms plus severe dizziness.								
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 : 110 T : 36.6 HR : 88 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K52.9	Noninfective gastroenteritis and colitis, unspecified					
Secondary	R11.10	Vomiting, unspecified					
Secondary	R42	Dizziness and giddiness					
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
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
Code	Generic	Duration	Instructions
1350-502201-1113	(SPORE OF BACILLUS CLAUSI : 2 BILLION/5ML) SUSPENSION	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) others
0097-230603-2091	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) others
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
☐ Surgery:		Estimated Costs	☐ Endoscopy:
☐ Physiotherapy:		☐ Other Procedures:	
Is the following required		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
<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 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.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
<i>Signature & Stamp</i>  Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. <i>Patient's Signature(Parent if minor)</i> 		
Date :		
Date : 30-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 reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.