eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**NITSUH MULUGETA BEYENE**	Gender:	**Female**	Validity Between:	**21/11/2024 and 20/11/2025**
Card No:	**F6BD-8B64-5594-27B5**	DOB:	**11/6/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1990-1968462-2**	Service Date:	**12-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0526363080**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45189**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):	**Date of Symptoms/illness started**		
Complaint	DD	MM	YYYY
PC: Upper abdominal pain that radiates to the chest and back Duration: 2weeks Vomiting also (2 episodes). No fever and no other complaint. Not hypertensive and not diabetic and has no other medical condition of note.			

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 : 126 T : 36.4 HR : 76 RR : 18

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

Type	Code	Diagnosis
Primary	N39.0	Urinary tract infection, site not specified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R10.13	Epigastric pain
Secondary	R11.10	Vomiting, unspecified

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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
9	GP Consultation	General Consultation	25.0000
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	8.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
86677	Antibody; Helicobacter pylori	Lab	25.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000

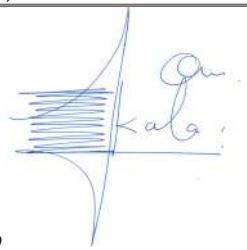
Code	Generic	Duration	Instructions
0265-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
6603-947301-0061	(ACTIVATED WOOD CHARCOAL : 250 MG) (SIMETHICONE : 80 MG) CAPSULES	5	Take 1Tablets 4Time(s) perDay For 5 Day(s) others
0188-232402-0391	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) before meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 certfy that all informaton mentoned are correct & that the medical services shown on this form were

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE

medically indicated & necessary for the management of this case.	*for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.*
Treating Physician Name : **Enomen Goodluck**	
Tel / Fax (important):	
 *Signature & Stamp* 	***Patient's Signature(Parent if minor)*** 
Date :	Date : 12-Dec-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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