eASOAP FORM

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

Patent Name:	**WASANA DILHANI PANANWELAGE**	Gender:	**Female**	Validity Between:	**15/10/2024 and 14/10/2025**
Card No:	**127E-CC23-3442-8D2F**	DOB:	**7/28/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1990-1819202-3**	Service Date:	**22-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0565636581**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39063**	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: vomiting 2 times 22/12/2024 nausea diarrhea epigastric pain			

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 : 109	T : 36	HR : 80	RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R19.7	Diarrhea, unspecified
Secondary	R11.2	Nausea with vomiting, unspecified

Type	Code	Diagnosis
Secondary	K29.00	Acute gastritis without bleeding
Secondary	E86.0	Dehydration
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

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
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
9	GP Consultation	General Consultation	25.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000

Code	Generic	Duration	Instructions
5278-230504-2891	(DEXTROSE ANHYDROUS : 2.7 G/200ML (SODIUM CHLORIDE : 0.52 G/200ML (POTASSIUM CHLORIDE : 0.3 G/200ML (SODIUM CITRATE : 0.58 G/200ML ORAL LIQUID	5	Take 1Solution 1 Time(s) per Day For 5 Day(s) others mix in 1.5 litre of water
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0005-150407-1172	(METOCLOPRAMIDE : 10 MG TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0152-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

○ 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 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Enomen Goodluck**		

Tel / Fax (important):	
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 22-Dec-2024
Note: Claims must be submited along with supportng 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 efects 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.