

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MOHAMED MOSSAD ABBAS MOSSAD ABBAS	Gender:	Male	Validity Between:	15/01/2024 and 14/01/2025
Card No:	ACF1-D038-497B-7716	DOB:	9/24/1983 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1983-7902183-9	Service Date:	05-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0525949843		
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:	42659	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint co abdominal pain heart burn 1st jan . 2024 oe chest is clear no added sounds restless smoker						DD	MM	YYYY
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 : 125	T : 36.6	HR : 74	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	K29.00	Acute gastritis without bleeding				
Secondary	R10.9	Unspecified abdominal pain				
Secondary	R12	Heartburn				

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:		

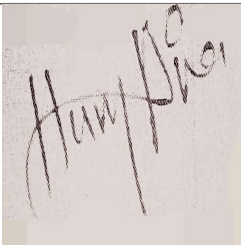
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
86140	C-reactive protein;	Lab	15.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
86677	Antibody; Helicobacter pylori	Lab	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0005-136501-0391	(HYOSCINE : 10 MG FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
1267-141614-1112	(ALUMINIUM HYDROXIDE : 225 MG/5ML (SIMETHICONE : 25 MG/5 ML (MAGNESIUM HYDROXIDE : 200 MG/5ML SUSPENSION	1	Take 10 ml 3 times in a day
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	7	Take 1Capsule 2 Time(s) per Day For 7 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	Estimate Cost
<i>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>		<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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : Humaira		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 05-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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