eASOAP FORM

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

Patent Name:	**MENNAALLAH MOHAMED ABDELSALAMABDELHAKIM**	Gender:	**Female**	Validity Between:	**23/05/2024 and 22/05/2025**
Card No:	**2727-E6DA-132C-06C9**	DOB:	**6/26/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-3835815-3**	Service Date:	**15-Jan-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0586194899**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI NATIONAL INSURANCE AND REINSURANCE CO**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45547**	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
CO VOMITing 4 times diarrhea 8 times fever on and off dehydration 13th jan. 2025 h/f outside food oe chest is clear no added sounds restless vape			

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 : 103 T : 35.5 HR : 78 RR : 18

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

Type	Code	Diagnosis
Primary	A09	Infectious gastroenteritis and colitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R19.7	Diarrhea, unspecified
Secondary	R11.10	Vomiting, unspecified
Secondary	R10.9	Unspecified abdominal pain
Secondary	E86.0	Dehydration

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

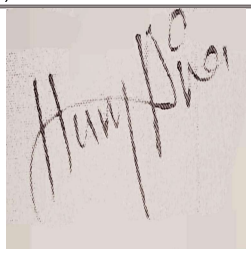
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0102-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
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

Code	Generic	Duration	Instructions
1795-502202-1451	(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	5	Take 1Capsule 3 Time(s) per Day For 5 Day(s) others
0097-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others
0195-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
7096-142902-0061	(CEFIXIME : 400 MG) CAPSULES	7	Take 1Capsule 1Time(s) perDay For 7 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 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 : **Humaira**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 15-Jan-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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