

eASOAP FORM

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

Patent Name:	WARDA SHAFIK TAWFIK IBRAHIM	Gender:	Female	Validity Between:	20/02/2024 and 19/02/2025
Card No:	9240-80CD-9BDC-75E9	DOB:	2/1/1993 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1993-8618895-9	Service Date:	15-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0565410545		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	40869	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 : epigastric pain , and rt hypochondrial pain , weight gain , joint pain for 10 days	
hx of chelecystectomy 5 month back	

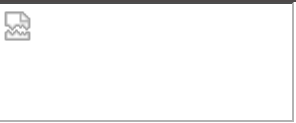
Complaint								
no other med conditions								
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started		
						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
						DD	MM	YYYY
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:			
What date did the Patient 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 : 104 T : 36 HR : 84 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Primary	K29.00	Acute gastritis without bleeding						
Secondary	R10.13	Epigastric pain						
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	

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
86677	Antibody; Helicobacter pylori	Lab	25.0000

Code	Generic	Duration	Instructions
4937-189409-1111	(CALCIUM CARBONATE : 80 MG/5ML) (SODIUM BICARBONATE : 133.5 MG/5ML) (SODIUM ALGINATE : 250 MG/5ML) SUSPENSION	14	Take 1Tablets 3 Time(s) per Day For 14 Day(s) after meal
1513-242802-1751	(PANTOPRAZOLE (AS SODIUM) : 40 MG) GASTRO-RESISTANT TABLETS	15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) morning empty stomach

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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 : SANDIA		
Tel / Fax (important):		
 <i>Signature & Stamp</i>	 <i>Patient's Signature(Parent if minor)</i>	

 Dr. Sandia Bhojwani General Practitioner DHA No: 65900212-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	
Date :	Date : 15-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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