eASOAP FORM



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

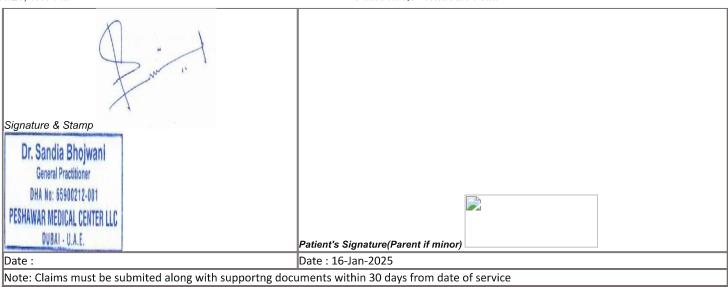
Patent Name: **HUSNA MURAD SHARIF** Gender: Female Validity Between: 15/10/2024 and 04/07/2025 1/6/2000 12:00:00 Coverage Information Card No: 146F-AFFE-6BDF-8CDD DOB: **Out Patient** AM for: RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-2000-3190365-9 Service Date: 16-Jan-2025 Radiology: Covered Patent's Tel No: 0585709105 Threshold Policy Holder: Limit: Payer Name: MetLife Class: Normal Out-Patent: Patent's File 45559 Co-Part: 20% Category: **Category B** Pharmacy: No: Gatekeeper: Consultation: Laboratory: Covered Referral No: Referred Service: CLIDICATIVE ACCECCATAIT

Symptom(s)	as described by the	e patent (Chie	f Complain	t):				Date of	Symptom	s/illness sta	arted
Complaint							DD	MM	YYYY		
pc : epigas	tric pain , rt hypoch	ondrial pain,	for 1 week								
pain is sharp sometimes compressing , vomitting											
taking dian 35 for hormonal imbalance , less than a month											
o/e ; tensed and tender abdomen at rt hpochondrium											
. ,		·									
									+		
								Date of Symptoms/illness started			
Past Medical Surgical History?			○Yes		O No		DD	MM	YYYY		
								Date of	Symptom	s/illness st	 arted
Obs/Gyn Cla	ıms							DD	MM	YYYY	
Para	☐ Gravida:	□ АВ:	LMP:	Marital Stati	us:	Marital Date:					
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	l the Deticat fact foot		. O to /o	\ al al							
	the Patient first feel	_			•						
ls the Patient	under any type of Tr	eatment? O	Yes ○ No	if yes, indica	ite what Asse	ssment and since	when:				
OBJECTIVE	ASSESSMENT(To	be completed b	y Physician)							
Clinical Findings :					Vital Signs : : 18	B/P : 113	T:3	36 HR : 87			RR
Assessment	/Diagnosis : O		Chronic	O Confirm	ed OSus _l	pected					

Туре	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R11.2	Nausea with vomiting, unspecified

Secondary		KI	.1.2	ina	usea with vo	miting, unspecified				
ACCIDENT/OCC	CUPATION	AL Claim I	nformaton	(complete if	claim is a re	sult of accident or work	related illne	ss/injury)		
Accident or illness due to work?				Injury due t accident?	o road	Describe how the accide	elated injury/illne	ss occur:		
○ Yes ○ No				○Yes ○I	No					
Date of accident or beginning of illness:										
MEDICAL PLAN	l Itemized	Original In	voices and	Applicable P	rescriptions ,	/ Reports / Results must	be enclosed t	to consider claim		
CPT Code	PT Code Treatment							Туре	Price	
9	GP Cons	GP Consultation					General Consultatio	25.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular							co.Pay	10.0000	
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							al, Co.Pay	40.0000	
0005- 150403- 1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION							Pharmacy	0.9000	
0005- 174202- 0781	RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION							Pharmacy	34.0000	
0102- 152902- 1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION 5.0							5.0000		
85004	Blood count; automated differential WBC count					Lab	5.0000			
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478) 45.000							45.0000		
Code Generic				Duration Instruction			ns			
No Prescriptio	ns History	Found								
O Pharmacy: Esti			Estmated (Estmated Costs		O Laboratory / Radiology:		Estmated Costs		
Is the following required			O Surgery:		○ Endoscopy:					
			O Physiotherapy:			Other Procedures:				
						If yes please specify				
le In-nationt Doc	nuired 2 Lo	agth of Star				Indicate Provider			stimate Cost	
Is In-patient Required? Length of Stay Indicate Provider Estimate Cost I hereby certfy that all information mentioned are correct I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization										

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Emp	oloyer or other Organizaton
& that the medical services shown on this form were	to release any informaton regarding my medical condito	on and history to NEXtCARE
medically indicated & necessary for the management of	for the purpose of determining insurance benefts. Medic	cal management is the sole
this case.	responsibility of doctor and the patent.	
Treating Physician Name : SANDIA		
Tel / Fax (important):		



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