

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	SHAUKAT ALI KAMIL HASSAN	Gender:	Male	Validity Between:	05/09/2024 and 04/09/2025
Card No:	287D-877C-EBF3-04EF	DOB:	1/3/1994 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1994-0637549-5	Service Date:	26-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0543979347		
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:	35790	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

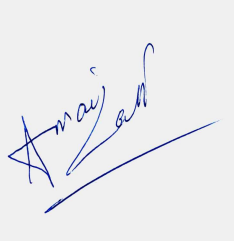
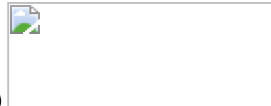
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint follow up tested positive for stool h pylori came for med refill						DD	MM	YYYY
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 176 T : 37 HR : 109 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	K29.00	Acute gastritis without bleeding			
Secondary	R11.0	Nausea			

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	
9.01	Follow-up consultation	General Consultation		0.0000	
Code	Generic	Duration	Instructions		
0435-189401-1112	(CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION	7	Take 1Syrup 3 Time(s) per Day For 7 Day(s) after meal		
0435-189501-2821	(SODIUM ALGINATE : N/A) (POTASSIUM BICARBONATE : N/A) SUSPENSION (PEPPERMINT FLAVOR)	7	Take 1Syrup 1 Time(s) per Day For 7 Day(s) after meal		
4075-242802-1562	(PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE CAPSULES	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) morning empty stomach		
0207-148601-0391	(CLARITHROMYCIN : 250 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others		
0138-116604-1171	(METRONIDAZOLE : 500 MG TABLETS	7	Take 1Tablets 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 hereby certify 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 benefets. Medical management is the sole responsibility of doctor and the patent.		
Treating Physician Name : DR Amaizah				
Tel / Fax (important):				
 Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E		 Patient's Signature(Parent if minor)		
Date :		Date : 26-Jan-2025		
Note: Claims must be submitted 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.