eASOAP FORM

AYOUB QASIM

MUHAMMAD QASIM



11/10/2024 and 10/10/2025

ADMINISTRATIVE

Patent Name:

The member is allowed for **Out Patient**

Male

Gender:

at the CITICARE MEDICAL CENTER LLC

Validity Between:

Card No: B3C1-0B18-941C-0D38		C-0D38	OOB:	4/2/1998 AM		Coverage Informaton for:		Out Patient				
Pin #:		dentty Card:			Network:		RN UAE (Al Ansari-AUH)- MEDGULF					
Policy Holder T		Service Date: Patent's Tel N Threshold Limit:	28-Jan-20 No: 05096761				Covere	ed				
Payer Name:	ORIENT INSURA P.J.S.C	NCE	Class:	Normal								
Category:	Category B	F	Out-Patent : Patent's File No:	26053		Pharmacy:		Co-Par	t: 20%			
Gatekeeper:			Consultaton :			Laboratory:			Covered			
Referral No: Referred Service:												
SUBJECTIVE ASS	ESSMENT											
Symptom(s) as	Symptom(s) as described by the patent (Chief Complaint):								Symptom	1	arted	
Complaint								DD	MM	YYYY		
pc: pain abdo	men , mucous seci	retion befor	e stool									
Past Medical Surgical History?				○Yes		○ No		Date o	f Symptom	s/illness st	tarted	
Obs/Gyn Claims									f Symptom		tarted	
		<u> </u>				l		DD	MM	YYYY		
Para	☐ Gravida:	☐ AB:	LMP:	Marital Statu	S:	Marital Date:						
What date did the	e Patient first feel sa	l ame / similar	Symptom(s)	· dd mm yyy	v	1						
	der any type of Trea					ssment and since	when:					
	SESSMENT(To be			, ,								
Clinical Finding		completed b	y Filysiciali)		Vital Signs :	R/D · 12/	T:3	6	HR:	86	RR	
					: 18	5/1 . 124	1.5	U	1111	00	TXIX	
Assessment/Dia	agnosis : O A		Chronic TOM	O Confirme	ed OSusp	ected						
Туре		Code		Diagnosis								
Primary		K29.00		Acute gastritis without bleeding								
Secondary		R14.0		Abdominal distension (gaseous)								
Secondary K58.2		K58.2	Mixed irrita		ble bowel syndrome							
ACCIDENT/OCC	UPATIONAL Claim	Informator	(complete i	f claim is a re	esult of accid	lent or work rela	ted illne	ess/inju	ry)			
Accident or illness due to work? Injury due accident?				to road Describe how the accident or work			or work	related	injury/illne	ess occur:		
			○ Yes ○	○ Yes ○ No								
Date of accident or beginning of illness:					1							
MEDICAL PLAN	Itemized Original I	nvoices and	l Applicable I	Prescriptions	/ Reports / F	Results must be e	enclosed	to cons	ider claim			

CPT Code	Trea	atment						Туре	Price	
9	GP	Consultation						General Consultation	25.0000	
83718	Lipo	protein, direct m	neasurement; high den	sity cholester	cholesterol (HDL cholesterol)			Lab	15.0000	
86141	C-re	eactive protein; h	igh sensitivity (hsCRP)					Lab	30.0000	
85027	Blo	od count; comple	ete (CBC), automated (I	lgb, Hct, RBC, WBC and platelet count)				Lab	15.0000	
Code	Code Generic				Duration Ins			nstructions		
0005-119805- 1173 (PREDNISOLONE : 5 MG) TABLETS					10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others				
2150-57520 1171	2150-575201- (CALCIUM : 400 MG (VITAMIN D3 : 200 1171 (ZINC : 4 MG TABLETS				Take Day			1 Unit(s), 1 Time(s) per Day For 30 s)		
1504-575701- (DIGESTIVE ENZYMMES PROPRIETARY 1451 (HARD GELATIN)				BLEND : 220 I	MG) CAPSULES	7	Take 1 Day(s)	ay For 7		
0135-22340 1171	(NAPROXEN : 500 MG TABLETS					3	Take 1Tablets 2 Time(s) per Day For Day(s) others			
0248-18780 1171	0248-187801- (DILOXANIDE FUROATE : 250 MG) (MET 1171 TABLETS				E : 200 MG)	5	Take 1Tablets 2 Time(s) per Day Fo Day(s) others			
O Pharmacy: Estmated Costs					O Laboratory / Radiology:			Estmated Costs		
○ Surgery:				○ Endoscopy:						
Is the following required		O Physiotherapy:	Other Procedures:							
				If yes please specify				1		
Is In-patient Re	equire	d ? Length of Stay	ı		Indicate Provide	er		Estim	ate Cost	
I hereby certf & that the me medically indi this case.	y tha dical cated	t all informaton r services shown c I & necessary for	mentoned are correct on this form were the management of	to release an for the purpo	y informaton reg	garding my l ng insurance	medical	rer, Employer or other O conditon and history to s. Medical management	NEXtCARE	
		lame : DR Amaiz a	ah							
Tel / Fax (important):										
Signature & St Dr. Amaizah General Prac DHA: 984865 CITICARE MEDIC	Ishtiad titioner 53-001									

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 final opinion will be given by the NEXtCARE claims doctors.

Date: 28-Jan-2025

Note: Claims must be submited along with supporting documents within 30 days from date of service

Patient's Signature(Parent if minor)

DUBAI - U.A.E

Date :