eASOAP FORM

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

Patent Name:	**JESSICA JADE COX**	Gender:	**Female**	Validity Between:	**12/10/2024 and 11/10/2025**
Card No:	**2EED-07BB-C8FC-1051**	DOB:	**11/3/2001 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2001-5172597-3**	Service Date:	**03-Feb-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0529033886**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45271**	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: nausea since friday can not eat well or drink well. nause and vomitting after even drinking water fatigue weakness restless bodypain since 3 days feel extremly weak oe: chest is clear throat normal pt looks dehydrated			

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 : 119 T : 36.5 HR : 86 RR : 18

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

Type	Code	Diagnosis
Primary	R11.0	Nausea
Secondary	R11.2	Nausea with vomiting, unspecified
Secondary	R53.83	Other fatigue
Secondary	R45.1	Restlessness and agitation
Secondary	M79.10	Myalgia, unspecified site

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
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0005-150403-1021	PREMOSAN	Pharmacy	0.9000
9	GP Consultation	General Consultation	25.0000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000

Code	Generic	Duration	Instructions
2027-560101-0391	(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0265-150407-1171	(METOCLOPRAMIDE : 10 MG TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	10	Take 1Tablets 2 Time(s) per Day For 10 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 : **SANDIA**		
Tel / Fax (important):		

Signature & Stamp Dr. Sandia Bhojwani General Practitioner DHA No: 65900212-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 03-Feb-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	