eASOAP FORM

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

Patent Name:	**SAIMA MUSHTAQ MUSTHAQ**	Gender:	**Female**	Validity Between:	**14/11/2024 and 13/11/2025**
Card No:	**B55B-9F5A-6E0B-AF2A**	DOB:	**12/1/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:	**Enter P.O.**	Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-1217800-7**	Service Date:	**14-Feb-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0503915720**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40621**	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
C/O STOMACH PAIN ,REFLUX ,DISTURBED BOWEL HABITS SINCE fever 2 DAYS constipation and cramping pain for 3 days HISTORY OF IBS AND GASTRITIS WITHOUT BLEEDIN			

Complaint
o/e look pale , lethargic , dehydrated tense tender abdomen bowel sounds sluggish

Past Medical Surgical History?	○ Yes	○ No

Date of Symptoms/illness started		
DD	MM	YYYY

Obs/Gyn Claims					
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:

Date of Symptoms/illness started		
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 : 113 T : 36 HR : 86 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R14.0	Abdominal distension (gaseous)
Secondary	K59.00	Constipation, unspecified
Secondary	K58.1	Irritable bowel syndrome with constipation
Secondary	E86.0	Dehydration

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

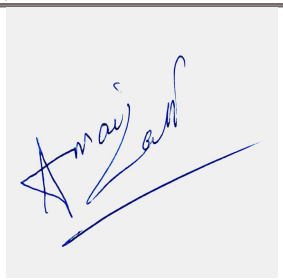
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
82043	Albumin; urine, microalbumin, quantitative	Lab	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
86038	Antinuclear antibodies (ANA);	Lab	25.0000
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	Pharmacy	5.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
86160	Complement; antigen, each component	Lab	10.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
0186-143701-0061	(CELECOXIB : 200 MG) CAPSULES	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) others
0005-119805-1174	(PREDNISOLONE : 5 MG TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others
2150-575201-1171	(CALCIUM : 400 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM : 100 MG) (ZINC : 4 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
1291-170801-1161	(LACTULOSE : 66.7%) SYRUP	3	Take 30ML 1 Time(s) per Day For 3 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 : **DR Amaizah**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 14-Feb-2025	
Note: Claims must be submited 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.