eASOAP FORM

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

Patent Name:	**AGNES NAMALE**	Gender:	**Female**	Validity Between:	**16/09/2024 and 15/09/2025**
Card No:	**5331-B3B0-E781-93AE**	DOB:	**3/13/1994 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1994-8145097-3**	Service Date:	**04-Apr-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0561556821**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42427**	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 : BRWONISH DISCHERGE FROM VAGINA , ACCOCIATED WITH FOUL SMELL AND IRRITATIONS AND LOWE ABD PAIN O/E : LOOK LETHRAGIC					
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 : 120 T : 37.4 HR : 74 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	N76.0	Acute vaginitis
Secondary	R21	Rash and other nonspecific skin eruption

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	GP Consultation	General Consultation	25.0000
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	Lab	5.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000

Code	Generic	Duration	Instructions
0138-169101-1451	(DOXYCYCLINE : 100 MG CAPSULES (HARD GELATIN	5	Take 1Capsule 1Time(s) perDay For 5 Day(s) after meal
6953-975201-4641	(BISMUTH SUBGALLATE : 100 MG) (HYDROLYZED VEGETABLE COLLAGEN : 15 MG) (HYDRASTIS CANADENSIS : 10 MG) (CALENDULA OFFICINALIS : 10 MG) (CURCUMA LONGA : 10 MG) OVULES PESSARY	3	intravaginally

○ 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  Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 04-Apr-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		