

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	NITSUH MULUGETA BEYENE	Gender:	Female	Validity Between:	21/11/2024 and 20/11/2025
Card No:	F6BD-8B64-5594-27B5	DOB:	11/6/1990 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1990-1968462-2	Service Date:	19-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0526363080		
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:	45189	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

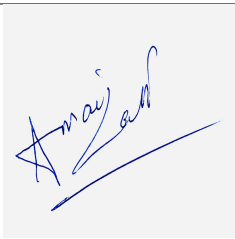
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
pc: severe pain in abdomen , loose stool and vimitting 2 episodes								
fel week lethagic and shaking whie pain whic is 8 on pain scale								
o/e : pale , dehydarted								
tender epigastric region								
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 : 120 T : 37.4 HR : 76 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K29.00	Acute gastritis without bleeding					
Secondary	R52	Pain, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	E86.0	Dehydration					

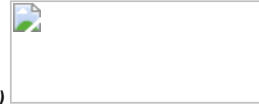
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)			
Accident or illness due to work?		Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No		☐ Yes ☐ No	
Date of accident or beginning of illness:			
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim			
CPT Code	Treatment	Type	Price
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
9	GP Consultation	General Consultation	25.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
87045	Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species	Lab	25.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
Code	Generic	Duration	Instructions
0005-136501-0391	(HYOSCINE : 10 MG) FILM COATED TABLETS	2	Take 1Tablets 2 Time(s) per Day For 2 Day(s) after meal
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	3	Take 1sachet 2 Time(s) per Day For 3 Day(s) others
3114-482003-0391	(CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal
☐ 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 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 benefsts. 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 : 19-Apr-2025

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

Disclaimer: NEXtCARE ASOAP form is used for claim creation 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 effects 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.