eASOAP FORM



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

WASANA DILHANI Patent Name: Gender: **Female** Validity Between: 15/10/2024 and 14/10/2025 **PANANWELAGE** 7/28/1990 12:00:00 Coverage Informaton Card No: 127E-CC23-3442-8D2F DOB: **Out Patient** ΑM for: RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: MEDGULF Natonal ID: 784-1990-1819202-3 Service Date: 19-Apr-2025 Radiology: Covered Patent's Tel No: 0565636581 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Payer Name: Class: Normal P.J.S.C Out-Patent: Patent's File 39063 Pharmacy: Co-Part: 20% Category: **Category B** No: Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referred Service:

SUBJECTIVE A	ASSESSMENT									
Symptom(s) as described by the patent (Chief Complaint):								Date of Symptoms/illness started		
Complaint								MM	YYYY	
pc: epigastric pain , nausea , vomitting 1 episode										
feels lethargy , oral intake is reduced										
o/e : look pale , lethargic										
Past Medical	Surgical History?			Yes		○ No	Da	Date of Symptoms/illness started		
- dat ivicultu	- Jungicui i iistory.			10 163		0 110	DD) MM	YYYY	
							D-	4f C	- /:llus ass at a who al	
Obs/Gyn Claims							DD	1	s/illness started	
☐ Para	Gravida:	□ АВ:	LMP:	Marital Stati	us:	Marital Date:				
What date did	I the Patient first feel s	ame / similar s	Svmptom(s) : dd mm vv\	/V	<u>I</u>				
	under any type of Tre					ssment and since	when:			
	ASSESSMENT(To be									
Clinical Find	· · · · · · · · · · · · · · · · · · ·	e completed by	rnysician		Vital Signs : : 18	B/P : 118	T : 36.8	HR:	78 RR	
Assessment II	/Diagnosis : O A		Chronic	O Confirm	ed OSusp	ected				
Туре		Code		Diagnosis						
Primary		K29.00		Acute gastritis without bleeding						
Secondary		R11.0		Nausea						
Secondary		R52		Pain, unspe	cified					

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); Co.Pay 10.0000 0005-150403- PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION Pharmacy 0.9000 0005-174202- 0005-174202-	ACCIDENT/OCCUPA	TIONAL Claim I	nformaton	(complete	if claim is a re	sult of accide	ent	or work related illne	ess/injur	y)			
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 9 GP Consultation General Consultation General Consultation 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); Co. Pay 10.0005 1005 PREMOSAN - (METOCLOPRAMIDE: 10 MG/2ML) SOLUTION FOR INJECTION Pharmacy 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); Co. Pay 40.0000 0005-174202- 0781 RISEK 40MG Pharmacy 34.0000 Code Generic 0219-533801- (ESOMEPRAZOLE (AS MAGNESIUM): 20 MG) FILM 0392 Pharmacy: Estmated Costs Olaboratory / Radiology: Estmated Costs Olaboratory / Radiology: Estmated Costs Surgery: Physiotherapy: Physiotherapy: Physiotherapy: Physiotherapy: Onther Procedures: If yes please specify In Jereby certify that o'll informomentomed are correct of the thermedical services shown on this form were medically indicated & necessary for the monagement of the purpose of determining insurance benefits. Medical monagement is the sole viscans and the potent. Treating Physician Name: DR Amaizah Tital Fax (important): Tital Fax (important): DIMBERIOLAL EITER INIMILIE INIMILI	IAccident or illness due to work?			, ,	to road	Describe how the accident or work				njury/illness occ	cur:		
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Price General Ge	○ Yes ○ No) No								
CPT Code Treatment Type Price Price	Date of accident or	beginning of illr	ness:			1							
9 GP Consultation General Consultation 25,0000 (Consultation 25,00	MEDICAL PLAN Iten	nized Original In	voices and	Applicable	Prescriptions ,	/ Reports / Re	esul	lts must be enclosed	to consid	der claim			
96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 0005-150403- PREMOSAN -(METOCLOPRAMIDE : 10 MG/ZML) SOLUTION FOR INJECTION Pharmacy 0.9000 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); co. Pay 40.0000 0005-174202- RISEK 40MG Pharmacy 34.0000 Code Generic Day 1 Take 1 Tablets 1 Time(s) per Day For 14 Day(s) morning empty stomach COATED TABLETS Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs Surgery: Physiotherapy: Other Procedures: If yes please specify Is In-patient Required? Length of Stay Indicated & necessary for the management of the reby authorize any Healthcare Provider, Insurer, Employer or other Organization that could be responsibility of doctor and the patent. Teating Physician Name: DR Amalizah Tel / Fax (important): Signature & Slamp DI Amaiziah Shifaq Genet Proclime Physician Name: DR Amalizah Tel / Fax (important): Title REQUIRED CETTER NIBILITE	CPT Code	Treatment							;	Price			
Substance of intramuscular Substance of i	9	GP Consultation	on							25.0000			
1021 PREMOSAN - (METOLLOPRAMIDE: 10 MG/2ML) SOLUTION FOR INJECTION Pharmacy 0.9000	96372			stic injection (specify substa	anc	e or drug);	Co.P	ay	10.0000			
Sin-patient Required 2 Length of Stay Indicate Provider Estimate Cost I hereby certify that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Tealing Physician Name : DR Amaizah Tel / Fax (important): Tax (important):		PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION							Phar	macy	0.9000		
Code Generic Duration Instructions	96365							substance or drug);	Co.P	ay	40.0000		
O219-533801- (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM O392 Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs Surgery: Endoscopy: Is the following required Surgery: Other Procedures: If yes please specify Is In-patient Required? Length of Stay Indicate Provider 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. Treating Physician Name: DR Amaizah Tel / Fax (important): Dr. Amaizah Ishilaq General Practitioner Dik. \$886553-01 CITICARE MEDICAL CENTER DIKINI. Life		RISEK 40MG							Phar	macy	34.0000		
O219-533801- (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM O392 Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs Surgery: Endoscopy: Is the following required Surgery: Other Procedures: If yes please specify Is In-patient Required? Length of Stay Indicate Provider 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. Treating Physician Name: DR Amaizah Tel / Fax (important): Dr. Amaizah Ishilaq General Practitioner Dik. \$886553-01 CITICARE MEDICAL CENTER DIKINI. Life									'				
OPHARMACY: Estmated Costs	Code	Generic				Duration Instructions							
Is the following required Surgery: Other Procedures: If yes please specify Is In-patient Required? Length of Stay Indicate Provider Is In-patient Required? Length of Stay Indicate Provider Intereby certify that all informaton mentoned are correct A that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: DR Amaizah Tel / Fax (important): Signature & Stamp DI. Amaizah Ishliaq General Praditione DH: \$486553.001 CITICARE MEDICAL CENTER INIAL - ILAF		•	•	20 MG) FILM									
Is the following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Indi	O Pharmacy:		Estmated Costs			O Laboratory / Radiology:			Estmated Costs				
Is the following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Indi			OSurger	v:		O Endosco	pv:						
Is In-patient Required? Length of Stay Indicate Provider Indicate Pr	Is the following required					<u> </u>							
Is In-patient Required? Length of Stay I hereby certfy that all informaton mentoned are correct **Rethat the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: DR Amaizah Tel / Fax (important): Signature & Stamp DI. Amaizah Ishliaq General Practitioner DHA: 94466553-001 CITICARE MEDICAL CENTER NIRAL-IJAF		- injection app			-								
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. Treating Physician Name: DR Amaizah Tel / Fax (important): Signature & Stamp Dr. Amaizah Ishliaq General Pracilioner DHA: \$8486553-001 CITICARE MEDICAL CENTER NIRAL-IIA F							- 1		l				
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: DR Amaizah Tel / Fax (important): DI. Amaizah Ishliaq General Praclitioner DHx 9848553-001 CITICARE MEDICAL CENTER DIRAI-II A F			•										
medically indicated & necessary for the management of this case. Treating Physician Name: DR Amaizah Tel / Fax (important): Signature & Stamp Dr. Amaizah Ishiiaq General Practitioner DHA: 9848553-001 CITICARE MEDICAL CENTER DIRAL-II A F													
this case. Treating Physician Name: DR Amaizah Tel / Fax (important): Signature & Stamp Dr. Amaizah Ishliaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER NIRAL-ILAF					, , , , , , , , , , , , , , , , , , , ,								
Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DIRAI-II A F					1								
Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DIIRAL-II A F						-		•					
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER	Tel / Fax (important):												
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER													
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER		<											
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER	throw) and												
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER													
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER													
Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER	Signature & Stamn												
General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DURAL - II A F		\neg											
DHA: 98486553-001 CITICARE MEDICAL CENTER DURAL - II A F													
CITICARE MEDICAL CENTER DURAL-UA F	II .												
CHICARE MEDICAL GENTER													
DUBAI - U.A.E Patient's Signature(Parent if minor)	CITICARE MEDICAL CENTE	:R											
r auent 3 Signature(Farent II IIIIIIOI)	DUBAI - U.A.E				Patient's Sign	aturo/Paront if	mi	nor)					
Date : Date : 19-Apr-2025													

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.

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