eASOAP FORM

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

Patent Name:	**MA LENINA FLORES**	Gender:	**Female**	Validity Between:	**06/02/2025 and 05/02/2026**
Card No:	**841A-7357-3D8C-D766**	DOB:	**10/2/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-4159824-1**	Service Date:	**26-Apr-2025**	Radiology:	**Covered**
		Patent's Tel No:	**+971 50 406 5878**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46147**	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**		
	DD	MM	YYYY
Complaint pt came with right lower abdominal pain . for 3 days pain is not continous. she also complain of weight gain and disturbance in periods			

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 : 111 T : 36.8 HR : 74 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R10.84	Generalized abdominal pain
Secondary	R14.3	Flatulence
Secondary	E03.9	Hypothyroidism, unspecified

Type	Code	Diagnosis
Secondary	N94.6	Dysmenorrhea, unspecified

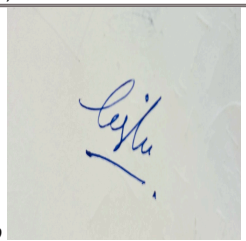
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

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
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	Lab	20.0000
84481	Triiodothyronine T3; free	Lab	40.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
81007	Urinalysis; bacteriuria screen, except by culture or dipstick	Lab	8.0000
82043	Albumin; urine, microalbumin, quantitative	Lab	10.0000

Code	Generic	Duration	Instructions
1267-141604-0082	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0042-136501-1173	(HYOSCINE : 10 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
1516-151709-0081	(SIMETHICONE : 42 MG) CHEWABLE TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 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 : **AISHA**		
Tel / Fax (important):		
Signature & Stamp  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 26-Apr-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.