

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	VIOLY PAGAL 8032047-5	Gender:	Female	Validity Between:	14/09/2024 and 13/09/2025
Card No:	8FA4-D282-210B-5497	DOB:	6/17/1977 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natnol ID:	784-1977-8032047-5	Service Date:	27-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0508047363		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	46559	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
nausea								
vomiting today one time								
epigastric pain								
pain in abdomen								
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 : 110 T : 36 HR : 84 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K29.00	Acute gastritis without bleeding					
Secondary	R10.13	Epigastric pain					
Secondary	R11.0	Nausea					
Secondary	R42	Dizziness and giddiness					
Secondary	E86.0	Dehydration					

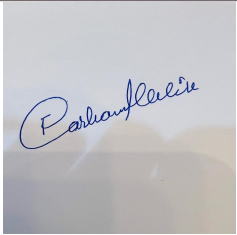
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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
9.01	Follow-up consultation	General Consultation	0.0000
83009	Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (eg, C-13)	Lab	40.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-150403-1021	PREMOSAN	Pharmacy	0.9000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000

Code	Generic	Duration	Instructions
0005-136501-0391	(HYOSCINE : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 2Time(s) perDay For 5 Day(s) others
0219-533801-0392	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) before meal
4937-189409-1111	(CALCIUM CARBONATE : 80 MG/5ML) (SODIUM BICARBONATE : 133.5 MG/5ML) (SODIUM ALGINATE : 250 MG/5ML) SUSPENSION	5	Take 10ML 3 Time(s) per Day For 5 Day(s) before meal
4884-627601-2901	(ONDANSETRON (AS HCL) : 4 MG) ORODISPERSIBLE TABLET	3	Take 1Tablets 2Time(s) perDay For 3 Day(s) before 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>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>	<i>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>	
Treating Physician Name : Dr.Farhan Iyas		
Tel / Fax (important):		
 Signature & Stamp Dr .Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E	Patient's Signature(Parent if minor)	
Date :	Date : 27-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 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 effects 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.