eASOAP FORM

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

Patent Name:	**LELYZAVETA RUD**	Gender:	**Female**	Validity Between:	**19/03/2025 and 18/03/2026**
Card No:	**AABF-ACF6-747A-FC93**	DOB:	**3/3/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1990-1964961-7**	Service Date:	**08-May-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0506650124**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46776**	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 : epigastric pain , burning , loss of appetite , bad taste , and lower abdominal pain hx of spicy food irregular menstural periods , weight gain pcos pattern on pelvic scan o/e : look dehydrated , epigastric tenderness			

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 : 36.8 HR : 68 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.01	Acute gastritis with bleeding
Secondary	R11.0	Nausea

Type	Code	Diagnosis
Secondary	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed
Secondary	R10.13	Epigastric pain
Secondary	E28.2	Polycystic ovarian syndrome

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
87338	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool	Lab	30.0000
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
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000

Code	Generic	Duration	Instructions
1195-933801-1171	(INOSITOL : 50 MG) (N-ACETYL CYSTEINE : 50 MG) (BETACAROTENE : 3 MG) (COENZYME Q10 : 20 MG) (VITAMIN D (AS D3) : 20 MCG) (NATURAL VITAMIN E : 4 MG) (ASCORBIC ACID (VITAMIN C) : 90 MG) (THIAMINE (VITAMIN B1) : 8 MG) (RIBOFLAVINE (VITAMIN B2) : 5 MG) (NICOTINAMIDE (VITAMIN B3) : 20 MG) (VITAMIN B6 : 10 MG) (FOLIC ACID : 400 MCG) (VITAMIN B12 : 20 MCG) (BIOTIN : 150 MCG) (PANTOTHENIC ACID (VITAMIN B5) : 6 MG) (MAGNESIUM : 60 MG) (IRON : 14 MG) (ZINC : 15 MG) (COPPER : 1000 MCG) (SELENIUM : 50 MCG)	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)
0435-189401-1113	(CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION	10	Take 10ML 2 Time(s) per Day For 10 Day(s) after meal
0219-533801-0391	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) morning empty stomach

○ 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 : 08-May-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	