

eASOAP FORM


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

Patent Name:	FELICIA NAMUTYABA	Gender:	Female	Validity Between:	22/05/2025 and 21/05/2026
Card No:	D540-8D21-DABE-900D	DOB:	8/26/2000 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2000-5443523-3	Service Date:	06-Jun-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0556228566		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	47080	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
patient came with severe epigastric pain along with heart burn for 1 week . epigastric tenderness . she has on and off diarrhea ,loss of appetite along with that complain of gas accumulation in stomach she is not sure about h.pylori result							
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)

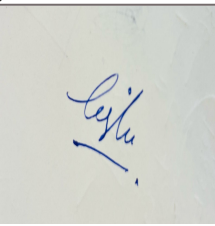
Clinical Findings :		Vital Signs : B/P : 120		T : 36.6	HR : 78	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected						
INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	K29.00	Acute gastritis without bleeding				
Secondary	R14.3	Flatulence				
Secondary	R12	Heartburn				
Secondary	R63.0	Anorexia				

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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-174202-0781	RISEK 40MG-(OMEPRazole : 40 MG) POWDER FOR INFUSION	Pharmacy	34.0000
86677	Antibody; Helicobacter pylori	Lab	25.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0270-189301-0081	(ALUMINIUM HYDROXIDE : N/A) (SODIUM BICARBONATE : N/A) (ALGINIC ACID : N/A) (MAGNESIUM TRISILICATE : N/A) CHEWABLE TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) AFTER MEAL
1516-151709-0081	(SIMETHICONE : 42 MG) CHEWABLE TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0097-397801-0391	(DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) BEFORE MEAL
0207-533801-1451	(ESOMEPRazole (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	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 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.</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 : 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 : 06-Jun-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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