

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:	07-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
epigastric pain and burning , nuasea , rduced appetite , bloating and reflux of food and feeling of discomfort previously tested positive for h. pylori was not compliant with meds o/e : look irritable due to pain tender epigastric gaseous abd distension								
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	B96.81	Helicobacter pylori as the cause of diseases classd elswhr					
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis					
Secondary	R10.13	Epigastric pain					
Secondary	R14.0	Abdominal distension (gaseous)					

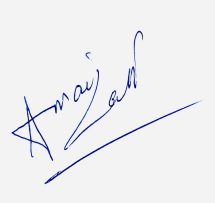
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
87338	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool	Lab	30.0000
9.01	Follow-up consultation	General Consultation	0.0000

Code	Generic	Duration	Instructions
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) after meal
0202-148602-0391	(CLARITHROMYCIN : 500 MG) FILM COATED TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 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
0005-136501-0391	(HYOSCINE : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0435-189401-1111	(CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION	14	Take 10ML 2 Time(s) per Day For 14 Day(s) after 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 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 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.	
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		
 Signature & Stamp 	 Patient's Signature(Parent if minor)	
Date :	Date : 07-Jun-2025	
Note: Claims must be submitted along with supportng 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.