eASOAP FORM

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

Patent Name:	**ANTONY KIM KANNAN KANNAN SWAMINATHAN**	Gender:	**Male**	Validity Between:	**15/06/2024 and 14/06/2025**
Card No:	**60B8-0C70-5A39-75E3**	DOB:	**6/13/1993 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1993-1925086-8**	Service Date:	**09-Jun-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0509207474**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MetLife**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**35224**	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
pt came with recurrent diarrhea 6 times for the last night pt feels very week along with he is dehydrated he also has a complain of indigetion advice to do stool antigen test			

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 : 142	T : 36.3	HR : 82	RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R12	Heartburn
Secondary	R19.7	Diarrhea, unspecified
Secondary	R53.1	Weakness
Secondary	E86.0	Dehydration

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

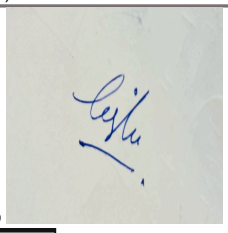
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-150403-1021	PREMOSAN	Pharmacy	0.9000
0005-174202-0781	RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION	Pharmacy	34.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000

Code	Generic	Duration	Instructions
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
1267-141604-0082	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	3	Take 1Powder 2 Time(s) per Day For 3 Day(s) others
0152-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 3 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 : 09-Jun-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		