eASOAP FORM

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

Patent Name:	**ANJELA KALINDA KABII**	Gender:	**Female**	Validity Between:	**11/09/2024 and**
Card No:	**5BAD-5AB3-822B-B17E**	DOB:	**4/22/1994 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1994-9730807-4**	Service Date:	**02-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0503959585**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47534**	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 Sympton**	
Complaint	DD	MM
pc : severe pain in abdomen , and nuasea , losse stool and epigastric burning , and burbing o/e : look pale		

Past Medical Surgical History?	◯ Yes	◯ No	**Date of Symptor**	
			DD	MM

Obs/Gyn Claims						**Date of Symptor**	
						DD	MM
☐ 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 : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding

Type	Code	Diagnosis
Secondary	E86.0	Dehydration
Secondary	R14.0	Abdominal distension (gaseous)
Secondary	D50.8	Other iron deficiency anemias
Secondary	R10.13	Epigastric pain
Secondary	R19.7	Diarrhea, unspecified

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/illn
◯ 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0005-136504-1021	SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION	Pharmacy
9	GP Consultation	General Consultatior
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy
0005-174202-0781	RISEK 40MG	Pharmacy
86140	C-reactive protein;	Lab
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab

Code	Generic	Duration	Instructions
1267-141614-1112	(ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION	5	Take 15ML 2 Time(s) p Day(s) after meal
0219-533801-0391	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s Day(s) morning empty

◯ 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
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 ot to release any informaton regarding my medical conditon and histo for the purpose of determining insurance benefts. Medical manage 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 : 02-Aug-2025
Note: Claims must be submited 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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX doctors.