eASOAP FORM

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

Patent Name:	**ARSLAN ANWAAR**	Gender:	**Male**	Validity Between:	**05/11/2024 and 04/11/2025**
Card No:	**9DE5-B448-E1EC-A5F5**	DOB:	**8/14/1989 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1989-9064000-9**	Service Date:	**17-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0557826432**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47635**	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,nausea HOPC pt presents with complaints of headache,nausea,epigastric pain since 2-3 days He also complaints of hard stools since 3 days History of food intake from restaurant O\E p\a soft,periumblical tenderness present Nil comorbs No history of drug allergy			

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 : 36.6 HR : 84 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	A09	Infectious gastroenteritis and colitis, unspecified

Type	Code	Diagnosis
Secondary	R10.9	Unspecified abdominal pain
Secondary	R30.0	Dysuria
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R11.0	Nausea

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
9	GP Consultation	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
81015	Urinalysis; microscopic only	Lab	8.0000
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
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000

Code	Generic	Duration	Instructions
1291-170801-1161	(LACTULOSE : 66.7%) SYRUP	5	Take 20Solution 1 Time(s) per Day For 5 Day(s) others
1795-502202-1451	(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0005-136501-0393	(HYOSCINE : 10 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 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 : **KEERTHANA**		
Tel / Fax (important):		

Signature & Stamp  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 17-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	