# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **FASIH AHMED MIZ** | Gender: | **Male** | Validity Between: | **11/07/2025 and 10/07/2026** |
| Card No: | **ABBC-C69A-5B4A-EA16** | DOB: | **10/8/2000 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-2000-1506270-4** | Service Date: | **25-Aug-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0508792073** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **47713** | 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** | | |
|---|---|---|---|
| | DD | MM | YYYY |
| **Complaint**<br>PC : GENERALIZE ABDOMINAL PAIN , HEARTBURN<br>HOPC : PT CAME WITH THE COMPLAIN OF GENERALIZE ABDOMINAL PAIN ALONG WITH HEARTBURN AND LOOSE STOOL OCCASIONALLY STARTED TWO WEEKS BACK<br>O/E ABDOMEN IS SOFT AND NON TENDOR<br>LOOK DEHYDRATED<br>ALLERGIES : WOOLEN | | | |

| **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 : 36.2 HR : 78 RR : 16 |
|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | R10.0 | Acute abdomen |
| Secondary | K29.00 | Acute gastritis without bleeding |
| Secondary | R12 | Heartburn |
| Secondary | R19.7 | Diarrhea, unspecified |
| Secondary | E86.0 | Dehydration |

| Type | Code | Diagnosis |
|---|---|---|
| Secondary | R10.84 | Generalized abdominal pain |
| Secondary | R14.3 | Flatulence |

| 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: | | |

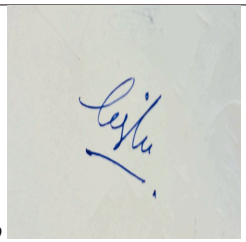
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

| CPT Code | Treatment | Type | Price |
|---|---|---|---|
| 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 |
| 0439-152905-1001 | LACTATED RINGERS INJECTION USP | Pharmacy | 7.5000 |
| 0005-136504-1021 | SCOPINAL | Pharmacy | 4.6000 |
| 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 |
| 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 |
|---|---|---|---|
| 1516-151709-0081 | (SIMETHICONE : 42 MG) CHEWABLE TABLETS | 7 | Take 1Tablets 1 Time(s) per Day For 7 Day(s) others |
| 0042-136501-1173 | (HYOSCINE : 10 MG) TABLETS | 7 | Take 1Tablets 1 Time(s) per Day For 7 Day(s) others |
| 1267-141614-1112 | (ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION | 7 | Take 1Syrup 2 Time(s) per Day For 7 Day(s) others |
| 0207-533801-1451 | (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN) | 7 | Take 1Tablets 2 Time(s) per Day For 7 Day(s) EMPTY STOMACH |

| ◯ 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*<br>  <br>Dr. Aisha Umer<br>Physician- General Practitioner<br>DHA- 40131439-002<br>CITICARE MEDICAL CENTER<br>DUBAI - U.A.E | ***Patient's Signature(Parent if minor)***  |
| Date : | Date : 25-Aug-2025 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |