

# eASOAP FORM



## ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CE**

|                      |                             |                      |                         |                             |                             |
|----------------------|-----------------------------|----------------------|-------------------------|-----------------------------|-----------------------------|
| Patent Name:         | ROMART CABRERA<br>ESGUERRA  | Gender:              | Male                    | Validity Between:           | 19/06/2024 and ' 19/06/2025 |
| Card No:             | 2293-937D-44C0-8CAF         | DOB:                 | 6/9/1992 12:00:00<br>AM | Coverage Informaton<br>for: | Out Patient                 |
| Pin #:               |                             | Identty Card:        |                         | Network:                    | RN UAE (AI Ans: MEDGULF     |
| Natonal ID:          | 784-1992-3643752-3          | Service Date:        | 16-Jul-2024             | Radiology:                  | Covered                     |
| Policy Holder:       |                             | Patent's Tel No:     | 0502609363              |                             |                             |
|                      |                             | Threshold<br>Limit:  |                         |                             |                             |
| Payer Name:          | ORIENT INSURANCE<br>P.J.S.C | Class:               | Normal                  |                             |                             |
|                      |                             | Out-Patent :         |                         |                             |                             |
| Category:            | Category B                  | Patent's File<br>No: | 43585                   | Pharmacy:                   | Co-Part: 20%                |
| Gatekeeper:          | No                          | Consultaton :        |                         | Laboratory:                 | Covered                     |
| Referral No:         |                             |                      |                         |                             |                             |
| Referred<br>Service: |                             |                      |                         |                             |                             |

## SUBJECTIVE ASSESSMENT

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                              |      |                           |                          |                        |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------|------|---------------------------|--------------------------|------------------------|----|
| <b>Symptom(s) as described by the patent (Chief Complaint):</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                              |      |                           |                          | <b>Date of Symptom</b> |    |
| <b>Complaint</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                              |      |                           |                          | DD                     | MM |
| <p>Severe headache</p> <p>Duration: 3hours duration (15/07/2024)</p> <p>Was said to have started insiduously immediately after eating staled food (pork).</p> <p>This isn't the first time he is having this kind of presentation.</p> <p>Patient is counselled to avoid staled port meals.</p> <p>Pain is scored 7/10.</p> <p>There is no fever, no pain in throat, no cough, no abdominal pain, no change in bowel habit, and no urine symptoms.</p> <p>he is not hypertensive and not diabetic and has no other medical condition in the past.</p> |                                   |                              |      |                           |                          |                        |    |
| <b>Past Medical Surgical History?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                   |                              |      | <input type="radio"/> Yes | <input type="radio"/> No | <b>Date of Symptom</b> |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                              |      |                           |                          |                        |    |
| <b>Obs/Gyn Claims</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                   |                              |      |                           |                          | <b>Date of Symptom</b> |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                   |                              |      |                           |                          |                        |    |
| <input type="checkbox"/> Para                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Gravida: | <input type="checkbox"/> 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 : 129<br>: 0 | T : 36.4 | HR |
|---------------------|--------------------------------|----------|----|

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected  
INDICATE DIAGNOSIS NOT SYMPTOM

| Type      | Code    | Diagnosis                                                |
|-----------|---------|----------------------------------------------------------|
| Primary   | R51.9   | Headache, unspecified                                    |
| Secondary | G43.901 | Migraine, unsp, not intractable, with status migrainosus |
| Secondary | R52     | Pain, unspecified                                        |

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

|                                                                                        |                                                                                    |                                                       |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------|
| Accident or illness due to work?<br><input type="radio"/> Yes <input type="radio"/> No | Injury due to road accident?<br><input type="radio"/> Yes <input type="radio"/> No | Describe how the accident or work related injury/illn |
| 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                 | Pric |
|----------|-----------------|----------------------|------|
| 9        | GP Consultation | General Consultation | 25.0 |

| Code             | Generic                                           | Duration | Instructions                             |
|------------------|---------------------------------------------------|----------|------------------------------------------|
| 1516-107902-1171 | (IBUPROFEN : 400 MG) TABLETS                      | 4        | Take 1Tablets 2 Time(s) per Day For meal |
| 0005-107001-0051 | (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | 4        | Take 2Tablets 3 Time(s) per Day For meal |
| 0006-199804-1971 | (SUMATRIPTAN : 10 MG) LIQUID FOR SPRAY (NASAL)    | 2        | Take 1Spray 1 Time(s) per Day For :      |

|                                 |                                      |                                               |                 |
|---------------------------------|--------------------------------------|-----------------------------------------------|-----------------|
| <input type="radio"/> Pharmacy: | Estimated Costs                      | <input type="radio"/> Laboratory / Radiology: | Estimated Costs |
| Is the following required       | <input type="radio"/> Surgery:       | <input type="radio"/> Endoscopy:              |                 |
|                                 | <input type="radio"/> Physiotherapy: | <input type="radio"/> Other Procedures:       |                 |
|                                 | If yes please specify                |                                               |                 |

Is In-patient Required ? Length of Stay

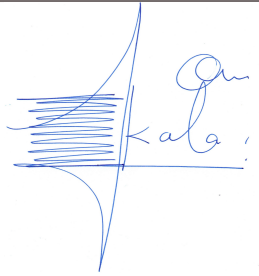
Indicate Provider

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.

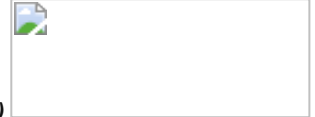
I hereby authorize any Healthcare Provider, Insurer, Employer or ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefsts. Medical manage responsibility of doctor and the patent.

Treating Physician Name : **Enomen Goodluck**

Tel / Fax (important):



Signature & Stamp



Patient's Signature(Parent if minor)

Date :

Date : 16-Jul-2024

Note: Claims must be submitted along with supporting documents within 30 days from date of service

Disclaimer: NEXtCARE ASOAP form is used for claim creation purposes. The data contained here should always be carefully reviewed. We will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEX doctors.