

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CE**

Patent Name:	SALAH UD DIN	Gender:	Male	Validity Between:	08/11/2023 and 08/11/2024
Card No:	2B69-192E-A57C-BB5D	DOB:	3/7/2002 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ans MEDGULF
National ID:	784-2002-6851900-4	Service Date:	16-Jul-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0527396496		
Payer Name:	MetLife	Threshold Limit:			
		Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	43433	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptom	
Complaint						DD	MM
Represented a few hours after, now complaining of upper abdominal pain, dizziness and weakness.							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						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 : T : HR :			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	K29.00	Acute gastritis without bleeding					
Secondary	R10.10	Upper abdominal pain, unspecified					
Secondary	R11.0	Nausea					
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/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
9.01	Follow-up consultation	General Consultation
0102-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
0005-136504-1021	SCOPINAL	Pharmacy
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy

Code	Generic	Duration	Instructions
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No Prescriptions History Found

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
	If yes please specify		

Is In-patient Required ? Length of Stay

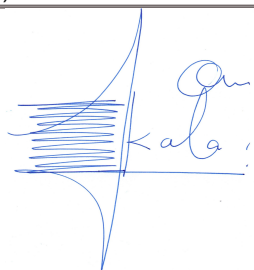
Indicate Provider

I hereby 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 histo for the purpose of determining insurance benefets. 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 supportng 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. NEXtCARE will not be held responsible for misuse of claims submissions or any adverse effects caused due to the claims submissions. NEXtCARE assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE doctors.