

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	KARMEGAM ANDYSAMY ANDYSAMY	Gender:	Male	Validity Between:	10/10/2023 and 09/10/2024
Card No:	4CE8-E688-75D9-3963	DOB:	7/23/1969 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1969-5317094-9	Service Date:	29-Jul-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0562378593		
		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43695	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):	Date of Symptoms/illness started		
Complaint	DD	MM	YYYY
co bodyache back pain swelling of the small joint dark colour urine 16 th july 2024 oe			

Complaint

small joint swelling back pain severe

chest is clear no added sounds

restless

taking antihypertensive medicine regularly name not remember

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 : 140
: 18

T : 36.9

HR : 116

RR

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

Type	Code	Diagnosis
Primary	M62.830	Muscle spasm of back
Secondary	M25.48	Effusion, other site
Secondary	R52	Pain, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	N39.0	Urinary tract infection, site not specified

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:		

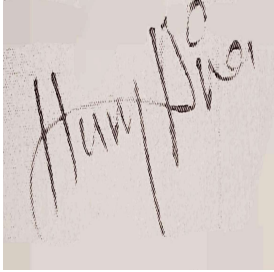
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
86431	Rheumatoid factor; quantitative	Lab	20.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000

Code	Generic	Duration	Instructions
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) others
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	1	Take 1Gel 1Time(s) perDay For 1 Day(s) others
1217-373201-2401	TOLPERISONE HCL	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

☐ 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	Estimate Cost
<i>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> <i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Humaira		
Tel / Fax (important):		

 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 Patient's Signature(Parent if minor)
Date :	Date : 29-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. NEXtCARE will not be held responsible for misuse of claims submission's 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 claims doctors.