eASOAP FORM

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

Patent Name:	**Maricar Valdez Navalta**	Gender:	**Female**	Validity Between:	**09/02/2024 and 08/02/2025**
Card No:	**6328-2943-4733-EDF0**	DOB:	**11/5/1974 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1974-2155027-4**	Service Date:	**31-Jul-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502286155**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43720**	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 co headache dizziness thirsty can not sleep previous night oe chest is clear no added restless			

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 : 200 T : 37 HR : 84 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I10	Essential (primary) hypertension
Secondary	R51.9	Headache, unspecified

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

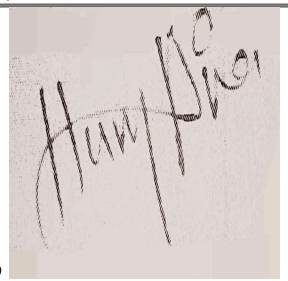
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
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
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	3	Take 1sachet 2 Time(s) per Day For 3 Day(s) others
0195-379202-1451	(AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN)	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

○ 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 : **Humaira**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 31-Jul-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

Disclaimer: NEXtCARE ASOAP form is used for claim creaton 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 efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.