

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	SARIA ABED	Gender:	Female	Validity Between:	02/05/2024 and 01/05/2025
Card No:	22C2-0407-C0E0-8287	DOB:	2/23/1998 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1998-6695208-0	Service Date:	11-Aug-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0563734048		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43598	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 pain inthe upper abdominal region 31st july 2024			
oe epigastric pain on and off			
she wants to do ultrasound abdomen			
chest is clear no added sounds			

Complaint								
stable						Date of Symptoms/illness started		
Past Medical Surgical History?		☐ Yes		☐ No		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:								

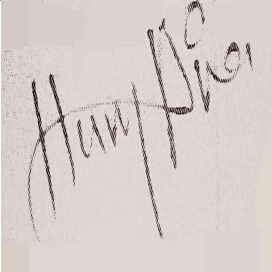
OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :		Vital Signs : B/P : 100		T : 37	HR : 76	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	K29.00	Acute gastritis without bleeding				
Secondary	K80.80	Other cholelithiasis without obstruction				
Secondary	E78.2	Mixed hyperlipidemia				

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	
Code	Generic	Duration	Instructions		
No Prescriptions History Found					
☐ 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>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):		
<i>Signature & Stamp</i>    <i>Patient's Signature(Parent if minor)</i>		
Date :	Date : 11-Aug-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 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 effects 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.