

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	AHSAN ALI REHMAT ULLAH	Gender:	Male	Validity Between:	24/03/2024 and 23/03/2025
Card No:	EFA6-DE8D-E593-120D	DOB:	11/26/1991 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-8034241-4	Service Date:	14-Aug-2024	Radiology:	Covered
		Patent's Tel No:	0522417239		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43194	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		
Complaint						DD	MM	YYYY
PC: Difficulty and pain during defecation								
There is associated protrusion of the anal mass								
Duration: 12days.								
There is no bleeding per rectum.								
Counselled on sitz bath.								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ 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 : 112	T : 37.8	HR : 124	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	K64.1	Second degree hemorrhoids
Secondary	K62.89	Other specified diseases of anus and rectum
Secondary	R50.9	Fever, unspecified
Secondary	K29.70	Gastritis, unspecified, without bleeding

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:		

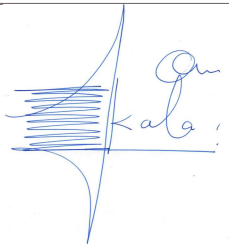
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000

Code	Generic	Duration	Instructions
0071-158501-0391	(HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION) : 450 MG) FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) before meal
0137-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0042-133702-1171	(BISACODYL : 5 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening
0054-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0016-119401-2231	(ZINC OXIDE : 296 MG) (BALSAM PERUVIAN SINE RESINA : 49 MG) (BISMUTH OXIDE : 24 MG) (BISMUTH SUBGALLATE : 59 MG) RECTAL SUPPOSITORIES	12	Take 1Suppository 1 Time(s) per Day For 12 Day(s) evening

☐ 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 14-Aug-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.