

eASOAP FORM

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

Patent Name:	ZINET MUHAMED SEID	Gender:	Female	Validity Between:	04/06/2024 and 03/06/2025
Card No:	F458-3C8D-C678-A832	DOB:	1/14/1984 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1984-2909050-7	Service Date:	18-Aug-2024	Radiology:	Covered
		Patent's Tel No:	0554585214		
Policy Holder:		Threshold Limit:			
Payer Name:	AL FUJAIRAH NATIONAL INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43862	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
co skin itching hand small laceration is there due to itching since april 2024								
dizzy headache ill looking since may 2024								
oe								
chest is clear no added sounds dehydrated								
rstless								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 96 T : 36.9 HR : 78		
			RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			

Type	Code	Diagnosis
Primary	L29.9	Pruritus, unspecified
Secondary	R51.9	Headache, unspecified
Secondary	D64.9	Anemia, unspecified
Secondary	L23.9	Allergic contact dermatitis, unspecified cause

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:		

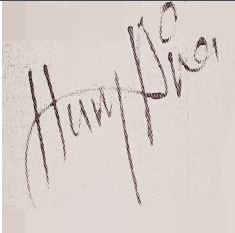
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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
83540	Iron	Lab	20.0000
83550	Iron binding capacity	Lab	30.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0102-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000

Code	Generic	Duration	Instructions
6792-956301-1171	(VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN C (ASCORBIC ACID) : 120 MG) (BIOTIN : 40 MCG) (FOLIC ACID : 0.4 MG) (PANTOTHENIC ACID (CALCIUM PANTOTHENATE) : 10 MG) (IODINE (AS POTASSIUM IODIDE) : 0.15 MG) (CALCIUM (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : 100 MG) (PHOSPHORUS (AS CALCIUM PHOSPHATE DIBASIC) : 48 MG) (MAGNESIUM(AS MAGNESIUM OXIDE) : 45 MG) (IRON (FERROUS FUMARATE) : 14 MG) (COPPER (AS SULPHATE	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0097-230603-0832	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 1 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 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>		<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 Muntaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 Patient's Signature(Parent if minor)
Date :	Date : 18-Aug-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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