eASOAP FORM

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

Patent Name:	**DARIA SUSON SEDURIFA**	Gender:	**Female**	Validity Between:	**01/10/2023 and 30/09/2024**
Card No:	**99FE-9B3C-2349-62CA**	DOB:	**10/19/1981 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1981-3962595-2**	Service Date:	**04-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0544996803**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41578**	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: type 2 diabetic low back ache asthma mild fungal infection dermatitis refill medication for diabties			

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 : 96 T : 36.8 HR : 88 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unsp
Secondary	B35.3	Tinea pedis
Secondary	I20.9	Angina pectoris, unspecified
Secondary	L20.9	Atopic dermatitis, unspecified

Type	Code	Diagnosis
Secondary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	M54.5	Low back pain

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
0027-109205-1171	(TERBINAFINE (AS HCL) : 125 MG) TABLETS	15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) others
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
1400-204902-0361	(METFORMIN HCL : 500 MG) (SITAGLIPTIN (AS PHOSPHATE) : 50 MG) EXTENDED RELEASE TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 1 Time(s) per Day For 30 Day(s) others
0011-528301-0391	(DAPAGLIFLOZIN (AS PROPANEDIOL) : 10 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0030-244101-0391	(CLOPIDOGREL : 75 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	60	Take 1Tablets 2 Time(s) per Day For 60 Day(s) after meal

○ 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 : **AHSAN HUSSAIN**		
Tel / Fax (important):		
Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI , U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 04-Sep-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.