

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
Policy Holder:		Patent's Tel No:	0544996803		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	41578	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
pc: type 2 diabetic								
low back ache								
asthma mild								
fungal infection								
dermatitis								
refill medication for diabties								
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 : 36.8 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

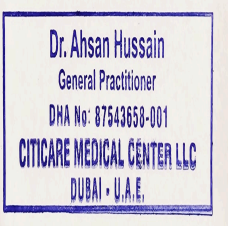
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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:	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 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 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 benefits. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : AHSAN HUSSAIN		
Tel / Fax (important):		
 		
Date :	Date : 04-Sep-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.