

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MYKA CELINE SAMSON	Gender:	Female	Validity Between:	25/06/2024 and 24/06/2025
Card No:	8240-1723-B961-98F0	DOB:	5/8/1987 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1987-7103980-1	Service Date:	06-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0509019462		
Policy Holder:		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42791	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: LOW BACK ACHE								
FUNGAL INFECTION								
BURNING MICTURATION								
HADACHE								
ASTHMA								
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 : 130 T : 36.8 HR : 82 RR : 20		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	M54.5	Low back pain			
Secondary	B35.3	Tinea pedis			
Secondary	N39.0	Urinary tract infection, site not specified			

Type	Code	Diagnosis
Secondary	G43.D0	Abdominal migraine, not intractable
Secondary	J45.21	Mild intermittent asthma with (acute) exacerbation
Secondary	B00.9	Herpesviral infection, unspecified

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
86140	C-reactive protein;	Lab	15.0000
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	Lab	8.0000

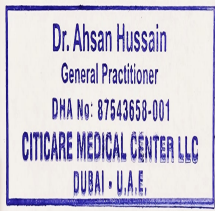
Code	Generic	Duration	Instructions
2048-565704-1391	(FORMOTEROL FUMARATE : 5MCG/DOSE) (FLUTICASONE PROPIONATE : 50 MCG/DOSE) AEROSOL INHALER	60	Take 1Puff 1 Time(s) per Day For 60 Day(s) others
1162-347205-1171	(ACICLOVIR : 400 MG) TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) after meal
0090-122303-0392	(ETORICOXIB : 90 MG) FILM COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) after meal
0188-292801-0112	(ZOLMITRIPTAN : 2.5 MG) COATED TABLETS	14	Take 1Spray 1 Time(s) per Day For 14 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0281-367801-0652	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) OINTMENT	30	Take 1Ointment 2 Time(s) per Day For 30 Day(s) others
0619-149914-0742	(DICLOFENAC SODIUM : 140 MG) PLASTER	15	Take 1Units 2 Time(s) per Day For 15 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

☐ 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 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 benefsts. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : AHSAN HUSSAIN		
Tel / Fax (important):		



Signature & Stamp



Patient's Signature(Parent if minor)



Date :

Date : 06-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.