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 and REINSURANCE 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?	○ 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 : 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:	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 : 06-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.