

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Constantino Zamora Enad	Gender:	Male	Validity Between:	01/10/2023 and 30/09/2024
Card No:	1E62-B92D-4C66-4011	DOB:	11/1/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1987-7596369-1	Service Date:	10-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0522680940		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44084	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: STOMACH PAIN\								
LOW BACK ACHE								
PREVIOUSLY KNOWN HYPERTENSIVE AND ON MEDICATION CONTROLLED								
HYPERLEPIDIMIC NEED TO CHECK LIPID PROFILE								
GOUT								
COUGH (BRONCHITS)								
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 : 150 T : 37.4 HR : 82 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	I10	Essential (primary) hypertension					
Secondary	E78.5	Hyperlipidemia, unspecified					
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis					
Secondary	M54.5	Low back pain					

Type	Code	Diagnosis
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	M1A.9XX0	Chronic gout, unspecified, without tophus (tophi)

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
84550	Uric acid; blood	Lab	15.0000
86677	Antibody; Helicobacter pylori	Lab	25.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000

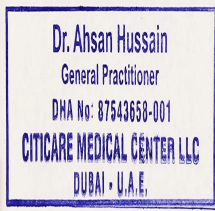
Code	Generic	Duration	Instructions
0071-155102-1171	(AMLODIPINE : 10 MG) (PERINDOPRIL : 5 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0003-375703-0391	(FEBUXOSTAT : 80 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0027-344907-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) before meal
0090-122303-0392	(ETORICOXIB : 90 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0110-116501-1451	(AMPICILLIN : 250 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 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 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 : 10-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.