eASOAP FORM

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

Patent Name:	**FAREENA ZARTASH SAAD UL ISLAM**	Gender:	**Female**	Validity Between:	**16/07/2024 and 15/07/2025**
Card No:	**83A6-0DD5-7153-6B6E**	DOB:	**11/25/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-1848042-3**	Service Date:	**14-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0526442897**		
Policy Holder:		Threshold Limit:			
Payer Name:	**TAKAFUL EMARAT**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37801**	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: UNCOMPLICATED WOUND AT LEFT FEET. Duration: 1day (13th/09/2024) Etiology: was cooking when a pot fell on her left foot resulting in the injury. Size: 2cm linear laceration on the dorsum of the left foot. Also complaints of low back pain. Duration: 1month			

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 : 109 T : 37.5 HR : 85 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	S81.812A	Laceration without foreign body, left lower leg, init encntr
Secondary	G89.11	Acute pain due to trauma
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
16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	Co.Pay	30.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
4884-622202-1171	(SERRAPEPTASE : 10 MG) TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others
0250-125803-0651	(POVIDONE IODINE : 10%) OINTMENT	7	Take 1Ointment 3 Time(s) per Day For 7 Day(s) others
6603-159502-1171	(SERRATIOPEPTIDASE : 10 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
1217-373201-2401	TOLPERISONE HCL	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
4179-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 : 14-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.