

# eASOAP FORM



## ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

|                   |                                    |                   |                              |                          |                                       |
|-------------------|------------------------------------|-------------------|------------------------------|--------------------------|---------------------------------------|
| Patent Name:      | <b>Muhamamd Bilal Khaliq Abdul</b> | Gender:           | <b>Male</b>                  | Validity Between:        | <b>21/06/2024 and 20/06/2025</b>      |
| Card No:          | <b>B29C-315C-1757-854B</b>         | DOB:              | <b>9/19/1995 12:00:00 AM</b> | Coverage Informaton for: | <b>Out Patient</b>                    |
| Pin #:            |                                    | Identty Card:     |                              | Network:                 | <b>RN UAE (Al Ansari-AUH)-MEDGULF</b> |
| Natonal ID:       | <b>784-1995-6652504-6</b>          | Service Date:     | <b>16-Sep-2024</b>           | Radiology:               | <b>Covered</b>                        |
| Policy Holder:    |                                    | Patent's Tel No:  | <b>0507864675</b>            |                          |                                       |
| Payer Name:       | <b>ORIENT INSURANCE P.J.S.C</b>    | Threshold Limit:  |                              |                          |                                       |
|                   |                                    | Class:            | <b>Normal</b>                |                          |                                       |
| Category:         | <b>Category B</b>                  | Out-Patent :      |                              | Pharmacy:                | <b>Co-Part: 20%</b>                   |
| Gatekeeper:       | <b>No</b>                          | Patent's File No: | <b>44177</b>                 | Laboratory:              | <b>Covered</b>                        |
| Referral No:      |                                    | Consultaton :     |                              |                          |                                       |
| Referred Service: |                                    |                   |                              |                          |                                       |

## SUBJECTIVE ASSESSMENT

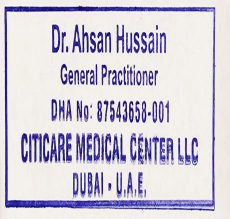
|                                                                                                                                                 |                                   |                              |      |                           |                          |                                         |    |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------|------|---------------------------|--------------------------|-----------------------------------------|----|------|
| <b>Symptom(s) as described by the patent (Chief Complaint):</b>                                                                                 |                                   |                              |      |                           |                          | <b>Date of Symptoms/illness started</b> |    |      |
| <b>Complaint</b><br><br>PC: HEADACHE<br><br>VOMITING                                                                                            |                                   |                              |      |                           |                          | DD                                      | MM | YYYY |
|                                                                                                                                                 |                                   |                              |      |                           |                          |                                         |    |      |
|                                                                                                                                                 |                                   |                              |      |                           |                          |                                         |    |      |
| <b>Past Medical Surgical History?</b>                                                                                                           |                                   |                              |      | <input type="radio"/> Yes | <input type="radio"/> No | <b>Date of Symptoms/illness started</b> |    |      |
|                                                                                                                                                 |                                   |                              |      |                           |                          | DD                                      | MM | YYYY |
|                                                                                                                                                 |                                   |                              |      |                           |                          |                                         |    |      |
| <b>Obs/Gyn Claims</b>                                                                                                                           |                                   |                              |      |                           |                          | <b>Date of Symptoms/illness started</b> |    |      |
| <input type="checkbox"/> Para                                                                                                                   | <input type="checkbox"/> Gravida: | <input type="checkbox"/> 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? <input type="radio"/> Yes <input type="radio"/> No if yes, indicate what Assessment and since when: |                                   |                              |      |                           |                          |                                         |    |      |

## OBJECTIVE / ASSESSMENT (To be completed by Physician)

|                                                                                                                                                                                                  |             |                                            |  |                         |  |          |  |         |  |         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------------------------------|--|-------------------------|--|----------|--|---------|--|---------|--|
| <b>Clinical Findings :</b>                                                                                                                                                                       |             |                                            |  | Vital Signs : B/P : 128 |  | T : 36.9 |  | HR : 70 |  | RR : 18 |  |
| <b>Assessment/Diagnosis :</b> <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Confirmed <input type="radio"/> Suspected<br><b>INDICATE DIAGNOSIS NOT SYMPTOM</b> |             |                                            |  |                         |  |          |  |         |  |         |  |
| <b>Type</b>                                                                                                                                                                                      | <b>Code</b> | <b>Diagnosis</b>                           |  |                         |  |          |  |         |  |         |  |
| Primary                                                                                                                                                                                          | G44.019     | Episodic cluster headache, not intractable |  |                         |  |          |  |         |  |         |  |
| Secondary                                                                                                                                                                                        | H57.10      | Ocular pain, unspecified eye               |  |                         |  |          |  |         |  |         |  |
| Secondary                                                                                                                                                                                        | R11.2       | Nausea with vomiting, unspecified          |  |                         |  |          |  |         |  |         |  |

|                                                                                                                          |                              |                                                                 |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------|
| <b>ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)</b> |                              |                                                                 |
| Accident or illness due to work?                                                                                         | Injury due to road accident? | Describe how the accident or work related injury/illness occur: |
|                                                                                                                          |                              |                                                                 |

| <input type="radio"/> Yes <input type="radio"/> No                                                                          |                                                                                                               | <input type="radio"/> Yes <input type="radio"/> 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                                                 |
| 96372                                                                                                                       | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | Co.Pay                                             | 10.0000                                                 |
| 0005-149902-1021                                                                                                            | CLOFEN                                                                                                        | Pharmacy                                           | 6.5000                                                  |
|                                                                                                                             |                                                                                                               |                                                    |                                                         |
| Code                                                                                                                        | Generic                                                                                                       | Duration                                           | Instructions                                            |
| 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 |
| <input type="radio"/> Pharmacy:                                                                                             |                                                                                                               | Estimated Costs                                    | <input type="radio"/> Laboratory / Radiology:           |
|                                                                                                                             |                                                                                                               |                                                    | Estimated Costs                                         |
| Is the following required                                                                                                   |                                                                                                               | <input type="radio"/> Surgery:                     | <input type="radio"/> Endoscopy:                        |
|                                                                                                                             |                                                                                                               | <input type="radio"/> Physiotherapy:               | <input type="radio"/> 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 benefets. Medical management is the sole responsibility of doctor and the patent. |               |
| Treating Physician Name : <b>AHSAN HUSSAIN</b>                                                                                                                                                 |                                                                                                                                                                                                                                                                                               |               |
| Tel / Fax (important):                                                                                                                                                                         |                                                                                                                                                                                                                                                                                               |               |
| <br>Signature & Stamp<br> | <br>Patient's Signature(Parent if minor)                                                                                                                                                                  |               |
| Date :                                                                                                                                                                                         | Date : 16-Sep-2024                                                                                                                                                                                                                                                                            |               |
| Note: Claims must be submitted 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.