

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Yahya Abdellattif Elsayed Abdellattif	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	F912-5819-A561-B690	DOB:	11/8/1993 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1993-6496547-7	Service Date:	16-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0502639520		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44179	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		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 PAIN							
FUNGAL INFECTION IN FEET							
URINARY TRACT INFECTION							
MIGRAINE							
DERMATITIS							
HERPESVIRAL INFECTION							
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 : 37.1 HR : 78 RR : 18	
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	
Secondary	G43.D0	Abdominal migraine, not intractable	

Type	Code	Diagnosis
Secondary	L40.9	Psoriasis, unspecified
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	Consultation GP	General Consultation	60.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	12.6000
86694	Antibody; herpes simplex, non- specific type test	Lab	75.6000

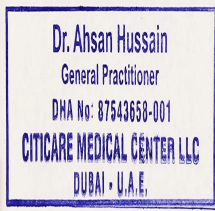
Code	Generic	Duration	Instructions
0015-102402-1172	(ACYCLOVIR : 400 MG) TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0006-102403-0153	ACYCLOVIR	30	Take 1Cream 3 Time(s) per Day For 30 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	30	Take 1Powder 3 Time(s) per Day For 30 Day(s) after meal
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
0281-367801-0432	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	30	Take 1Cream 2 Time(s) per Day For 30 Day(s) others
0619-149914-0742	(DICLOFENAC SODIUM : 140 MG) PLASTER	30	Take 1Units 2 Time(s) per Day For 30 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) before 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 : 16-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.