

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Harab Sarfraz Ahmad	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	7DF7-2797-F957-419F	DOB:	9/20/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-2797365-6	Service Date:	17-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0505878896		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44194	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 PC: HYPERTENSION KNOWN ASTHMATIC KNOWN LOW BACK PAIN STOMACH PAIN						DD	MM	YYYY
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:								

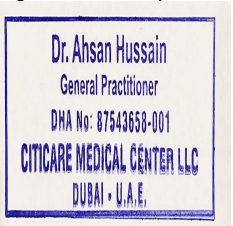
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :			Vital Signs : B/P : 130 T : 37.4 HR : 78 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	I10	Essential (primary) hypertension			
Secondary	J45.20	Mild intermittent asthma, uncomplicated			
Secondary	R73.9	Hyperglycemia, unspecified			
Secondary	M54.5	Low back pain			
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis			

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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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		
3044F	Most Recent Hemoglobin A1C (Hba1C) Level < 7.0% (Dm)	Co.Pay	78.0000		
86677	Antibody; Helicobacter pylori	Lab	75.6000		
Code	Generic	Duration	Instructions		
0027-179202-0391	(AMLODIPINE : 10 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1Time(s) perDay For 60 Day(s) others		
0281-367801-0432	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	30	Take 1Gel 2 Time(s) per Day For 30 Day(s) others		
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others		
0188-155602-0391	(ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others		
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	30	Take 1Powder 3 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		
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 2 Time(s) per Day For 30 Day(s) others		
☐ 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 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 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 : 17-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 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 effects 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.