

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Rolando Rubiano	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2024
Card No:	46D6-8214-839F-4A64	DOB:	1/23/1981 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1981-9460948-7	Service Date:	17-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0557345287		
Policy Holder:		Threshold Limit:			
Payer Name:	DUBAI INSURANCE COMPANY	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44199	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: ASTHMATIC KNOWN						
HYPERTENSIVE KNOWN						
STOMACH PAIN						
LOW BACK PAIN						
COUGH						
GOUT DIAGNOSED						
CAME TO REFILL MEDICATION						
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 : 134 T : 37 HR : 78 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J45.20	Mild intermittent asthma, uncomplicated	
Secondary	I10	Essential (primary) hypertension	
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis	

Type	Code	Diagnosis
Secondary	M54.5	Low back pain
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	M10.9	Gout, unspecified

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

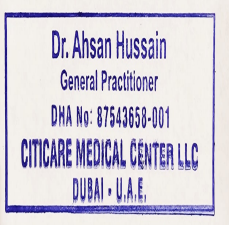
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
86677	Antibody; Helicobacter pylori	Lab	25.0000
84550	Uric acid; blood	Lab	15.0000

Code	Generic	Duration	Instructions
0071-155103-1171	(AMLODIPINE : 5 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
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 2 Time(s) per Day For 30 Day(s) others
0027-344907-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 12.5 MG) FILM COATED TABLETS	60	Take 1Tablets 1Time(s) perDay For 60 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) before meal
0090-122303-0392	(ETORICOXIB : 90 MG) FILM COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
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>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>		<i>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.</i>
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 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.