

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Maria Teresa Gutierrez Parro	Gender:	Female	Validity Between:	01/01/2024 and 31/12/2024
Card No:	AE93-CE54-1512-1F55	DOB:	2/15/1981 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1981-0486595-5	Service Date:	18-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0508570247		
Payer Name:	DUBAI INSURANCE COMPANY	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44217	Laboratory:	Covered
Referral No:		Consultaton :			
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						
COUGH						
HYPERLIPIDEMIA KNOWN						
HYPERTENSIVE PREVIOUSLY						
ASTHMATIC						
CAME TO REFILL MEDICATION						
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 : 134	T : 37	HR : 68	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J20.9	Acute bronchitis, unspecified				
Secondary	M54.5	Low back pain				
Secondary	E78.5	Hyperlipidemia, unspecified				
Secondary	I10	Essential (primary) hypertension				

Type	Code	Diagnosis
Secondary	J45.20	Mild intermittent asthma, uncomplicated

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
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000

Code	Generic	Duration	Instructions
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0071-155102-1171	(AMLODIPINE : 10 MG) (PERINDOPRIL : 5 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0090-312201-1171	(EZETIMIBE : 10 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 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) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	30	Take 1Gel 2 Time(s) per Day For 30 Day(s) others
0042-268301-1461	(TIOTROPIUM BROMIDE : 18 MCG) CAPSULES (HARD GELATIN) FOR INHALATION (DRY POWDER)	30	Take 1Powder 2 Time(s) per Day For 30 Day(s) others
0188-155602-0391	(ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) others
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 : 18-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.