

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Inayatullah Ghous Bakhsh	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	4C05-B373-D7FB-A7E0	DOB:	1/1/1985 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1985-2075384-3	Service Date:	19-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0544982343		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44240	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						DD	MM	YYYY
PC: ASTHMA TIC KNOWN								
STOMACH PAIN								
LOW BACK PAIN								
HYPERLIPIDEMIA								
HYPERTENSIVE KNOWN								
PSORIASIS								
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 : 140 T : 36.6 HR : 62 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J45.20	Mild intermittent asthma, uncomplicated			
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis			
Secondary	M54.5	Low back pain			
Secondary	E78.5	Hyperlipidemia, unspecified			

Type	Code	Diagnosis
Secondary	I10	Essential (primary) hypertension
Secondary	L20.9	Atopic dermatitis, unspecified

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

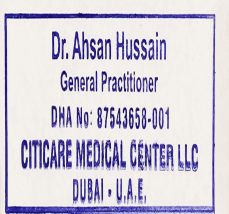
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
86677	Antibody; Helicobacter pylori	Lab	75.6000
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	88.2000

Code	Generic	Duration	Instructions
0090-312201-1171	(EZETIMIBE : 10 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	30	Take 1Tablets 1 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
0027-179202-0391	(AMLODIPINE : 10 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) others
0281-367801-0432	(CALCIPTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	60	Take 1Cream 2 Time(s) per Day For 60 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>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 benefets. 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 : 19-Sep-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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