

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Asad Mohammad Ali Butt	Gender:	Male	Validity Between:	30/06/2024 and 28/02/2025
Card No:	A97C-FAF6-43B0-44D7	DOB:	1/25/2000 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2000-1627290-6	Service Date:	20-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0558837036		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44251	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 1 YEAR							
MIGRAINE 1 MONTH							
KNOWN ASTHMATIC 1 YEAR							
FUNGAL INFECTION FEET							
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)

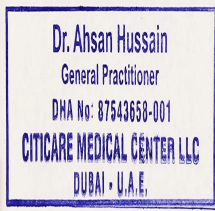
Clinical Findings :			Vital Signs : B/P : 110 T : 37 HR : 82 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	M54.5	Low back pain			
Secondary	B35.3	Tinea pedis			
Secondary	G43.D0	Abdominal migraine, not intractable			
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
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	Lab	8.0000
Code	Generic	Duration	Instructions
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others
0042-268301-1461	(TIOTROPIUM BROMIDE : 18 MCG) CAPSULES (HARD GELATIN) FOR INHALATION (DRY POWDER)	30	Take 1Tablets 2 Time(s) per Day For 30 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
0281-367801-0431	(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
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0619-149914-0741	(DICLOFENAC SODIUM : 140 MG) PLASTER	30	Take 1Units 2 Time(s) per Day For 30 Day(s) others
0188-292801-0112	(ZOLMITRIPTAN : 2.5 MG) COATED TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others
0027-109204-1171	(TERBINAFINE (AS HCL) : 250 MG) TABLETS	14	Take 1Tablets 3 Time(s) per Day For 14 Day(s) others
0027-109206-0151	(TERBINAFINE (AS HCL) : 1%) CREAM	15	Take 1Cream 3 Time(s) per Day For 15 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 : 20-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.