

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: ABDUL KAREEM	Gender: Male	Validity Between: 01/03/2024 and 28/02/2025
Card No: 136C-7C5A-E909-3276	DOB: 9/3/1996 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1996-7006447-8	Service Date: 20-Sep-2024	Radiology: Covered
	Patent's Tel No: 0505681083	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 44253	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: ASTHMATIC				
M LOW BACK PAIN				
HYPERLIPIDEMIA				
STOMACH PAIN				
CONSTIPATION				
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 : 112 T : 36.7 HR : 74 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				
Type	Code	Diagnosis		
Primary	J45.20	Mild intermittent asthma, uncomplicated		
Secondary	M54.5	Low back pain		
Secondary	E78.5	Hyperlipidemia, unspecified		
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis		

Type	Code	Diagnosis
Secondary	K59.00	Constipation, unspecified

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

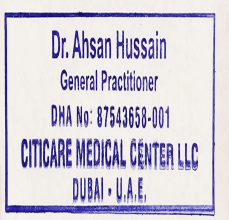
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
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
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
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 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
0619-149914-0741	(DICLOFENAC SODIUM : 140 MG) PLASTER	30	Take 1Units 2 Time(s) per Day For 30 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 1 Time(s) per Day For 30 Day(s) others
0481-382801-0391	(PRUCALOPRIDE (AS PRUCALOPRIDE SUCCINATE) : 1 MG) FILM COATED TABLETS	60	Take 1Tablets 1 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 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 : 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.