

eASOAP FORM

**ADMINISTRATIVE**The member is allowed for **Out Patient**at the **CITICARE MEDICAL CENTRE**

Patent Name:	Muhamamd Bilal Khaliq Abdul	Gender:	Male	Validity Between:	21/06/2024 and 21/06/2025
Card No:	B29C-315C-1757-854B	DOB:	9/19/1995 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans: MEDGULF
Natonal ID:	784-1995-6652504-6	Service Date:	22-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0507864675		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44177	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 Symptom	
Complaint						DD	MM
PC: HEADACHE							
ON AND OFF							
BLOOD PRESSURE CONSTANTLY HIGH FOR 7 DAYS							
ABOVE 130/80							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						DD	MM
☐ 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 : 124 RR : 18	T : 36.7	HR :
---------------------	------------------------------------	----------	------

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R51.9	Headache, unspecified
Secondary	I10	Essential (primary) hypertension

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/illne
☐ 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
9.01	Follow-up consultation	General Consultation

Code	Generic	Duration	Instructions
1217-373201-2401	TOLPERISONE HCL	15	Take 1Tablets 2 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

I hereby certfy 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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefets. Medical managemer responsibility of doctor and the patent.

Treating Physician Name : **AHSAN HUSSAIN**

Tel / Fax (important):



Signature & Stamp


Patient's Signature(Parent if minor)



Date :

Date : 22-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. We will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NEtcare has no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the Netcare doctors.