

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

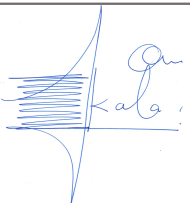
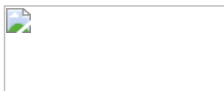
Patent Name:	ASHA THATTASSERIL PADMAVATHY NEELAKANDAN	Gender:	Female	Validity Between:	25/11/2023 and 24/11/2024
Card No:	7504-3D2B-B81F-852B	DOB:	5/25/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1978-7310218-6	Service Date:	29-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0564999790		
		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	37217	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: Fever, headache, and photophobia. Also has neck pain but no neck stiffness. Also white vaginal discharge, itching and painful micturition. Duration: 2days (26/09/2024). Also has a history of multiple hydradenitis suppurativa and has been referred on several occasion to the general surgeon but declined.								
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 : 122 T : 38.1 HR : 96 RR : 20			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	L73.2	Hidradenitis suppurativa					
Secondary	L03.311	Cellulitis of abdominal wall					
Secondary	L02.211	Cutaneous abscess of abdominal wall					
Secondary	R50.9	Fever, unspecified					
Secondary	G43.919	Migraine, unsp, intractable, without status migrainosus					
Secondary	K29.00	Acute gastritis without bleeding					
Secondary	N39.0	Urinary tract infection, site not specified					
Secondary	N77.1	Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr					
Secondary	B37.41	Candidal cystitis and urethritis					

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
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
Code	Generic	Duration	Instructions
0252-140201-0061	(FLUCONAZOLE : 150 MG) CAPSULES	1	Take 1Tablets 1 Time(s) per Day For 1 Day(s) others, the repeat after one week
0005-106601-0052	(PARACETAMOL : 500 MG) CAPLETS	4	Take 2Tablets 3 Time(s) per Day For 4 Day(s) after meal
0188-232401-0391	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) before meal
1395-397601-0391	(SUMATRIPTAN (AS SUCCINATE) : 100 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0067-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) after meal
☐ 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 benefets. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : Enomen Goodluck			
Tel / Fax (important):			
 Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		 Patient's Signature(Parent if minor)	
Date :		Date : 29-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 creaton 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 fnal opinion will be given by the NEXtCARE claims doctors.