eASOAP FORM

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

Patent Name:	**MUHAMMAD NADEEM MUHAMMAD ISHAQUE**	Gender:	**Male**	Validity Between:	**01/01/2024 and 3**
Card No:	**B21A-82AE-24EF-07FE**	DOB:	**1/1/1986 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1986-9616191-2**	Service Date:	**02-Oct-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502815556**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44374**	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
Chest pain, heaviness in the chest, cough and fever. Duration: 2days. A known asthmatic, hypertensive and diabetic. ECG advised.							
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 : 116 T : 37.6 HR : RR : 18

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

Type	Code	Diagnosis
Primary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	I10	Essential (primary) hypertension
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	I20.9	Angina pectoris, unspecified
Secondary	E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy

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
82947	Glucose; quantitative, blood (except reagent strip)	Lab
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
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) andautomated differential WBC count	Lab
93000	Electrocardiogram, routine ECGwith at least 12 leads; with interpretation and report	Co.Pay
9	Consultation GP	General Consultatic

Code	Generic	Duration	Instructions
0030-244101-0391	(CLOPIDOGREL : 75 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) Day(s) morning
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Units 1 Time(s) p Day(s) evening
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) Day(s) evening
0027-179203-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) Day(s) morning
0090-204901-0391	(SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 1000 MG) FILM COATED TABLETS	60	Take 1Tablets 2 Time(s) Day(s) after meal
0170-208601-1021	(INSULIN - GLARGINE : 100 IU/ML) SOLUTION FOR INJECTION	60	Take 25Units 3 Time(s) Day(s) after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 benefts. Medical managemer 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 : 02-Oct-2024
Note: Claims must be submited along with supportng 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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.