

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Muhammad Akram Muhammad Sarwar	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	E896-8CA6-BA18-2FB2	DOB:	3/1/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1978-5325743-0	Service Date:	07-Oct-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0553673112		
Payer Name:	ENAYA	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44425	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: Chest pain, weakness. Duration: 6hours. Radiates to the right arm and back, character is poorly described. Known hypertensive, diabetic and hyperlipidemic patient on routine medications but with poor compliance, Obese looking. Also complain of frequency of urine (hyperglycemia suspected).								
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 : 128 : 18	T : 37.3	HR : 94	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	I20.9	Angina pectoris, unspecified
Secondary	R07.9	Chest pain, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	E11.9	Type 2 diabetes mellitus without complications
Secondary	K29.00	Acute gastritis without bleeding
Secondary	N39.0	Urinary tract infection, site not specified

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:		

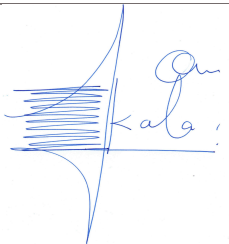
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
93000	Electrocardiogram, routine ECGwith at least 12 leads; with interpretation and report	Co.Pay	75.6000
9	Consultation GP	General Consultation	60.0000

Code	Generic	Duration	Instructions
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) before meal
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) after meal
0071-155104-1171	(AMLODIPINE : 5 MG) (PERINDOPRIL : 10 MG) TABLETS	60	Take 1Tablets 1Time(s) perDay For 60 Day(s) morning
0011-528302-0391	(DAPAGLIFLOZIN (AS PROPANEDIOL) : 5 MG) FILM COATED TABLETS	56	Take 1Tablets 1Time(s) perDay For 56 Day(s) after meal
1233-211703-0393	(ATORVASTATIN : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0030-244101-0391	(CLOPIDOGREL : 75 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) morning

☐ Pharmacy:	Estmated 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 : Enomen Goodluck		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 07-Oct-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.