

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	OMAR ABDUL RAHMAN HEMMAMI	Gender:	Male	Validity Between:	01/05/2024 and 30/04/2025
Card No:	54F0-2CF7-0727-3F4C	DOB:	1/1/1995 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1995-7046750-8	Service Date:	10-Oct-2024	Radiology:	Covered
		Patent's Tel No:	0567567452		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44466	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

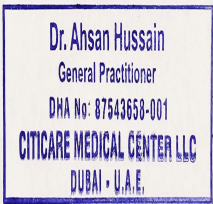
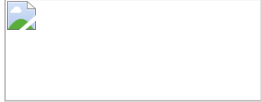
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started			
Complaint PC: DIARRHEA EPIGASTRIC PAIN FEVER LOW BACK PAIN						DD	MM	YYYY	
Past Medical Surgical History?						☐ Yes		☐ No	
						DD	MM	YYYY	
Obs/Gyn Claims						Date of Symptoms/illness started			
						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 : 122 T : 36.5 HR : 64 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R19.7	Diarrhea, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	K29.00	Acute gastritis without bleeding					
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis					
Secondary	M54.5	Low back pain					
Secondary	M62.830	Muscle spasm of back					

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
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000
2040-106618-1001	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
Code	Generic	Duration	Instructions
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0152-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0788-106705-1171	(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
			Estimated Costs
Is the following required		☐ Surgery:	
		☐ Endoscopy:	
		☐ Physiotherapy:	
		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
<i>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>		
<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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : AHSAN HUSSAIN		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 10-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.