## **eASOAP FORM**



ADMINISTRATI\	/E The	e member is allowed	d for <b>Out Patient</b>	at the CITICARE MEDICAL CENTER LLC					
Patent Name:	Ghaya Walid Walid	Gender:	Female	Validity Between:	01/01	/2024 and 31	/12/2026		
Card No:	8C44-0C84-AAD7-16C	1 DOB:	8/12/2008 12:00: AM	00 Coverage Informato for:	n Out P	Out Patient			
Pin #:		Identty Card:		Network:	RN U	AE (Al Ansar GULF	i-AUH)-		
National ID:	784-2008-7547360-3	Service Date: Patent's Tel No Threshold	14-Oct-2024 b: 0525850470	Radiology:	Cove	red			
Card No: 8C44  Pin #:  Natonal ID: 784-2  Policy Holder:  Payer Name: PRO  Category: Category: Category: No  Referral No: Referral No: Referred Service:  SUBJECTIVE ASSESSME Symptom(s) as descrift  Complaint  PC: PAIN IN UPPER TO  Past Medical Surgical I  Obs/Gyn Claims  Para Gravi  What date did the Patier is the Patient under any  DBJECTIVE / ASSESSI	DUBAI GOVERNMENT	( lace:	Normal						
	PROGRAM 1 (ENAYA)	Out-Patent :							
Category:	Category B	Patent's File No:	44517	Pharmacy:	Co-Pa	Co-Part: 20%			
Gatekeeper:	No	Consultaton:		Laboratory:	Cove	red			
Referral No: Referred Service:									
Symptom(s) as	described by the patent	(Chief Complaint):			Date of Symptoms/illi			d	
	JPPER TOOTH INCISOR LE	FT SIDE			DD	MM	YYYY		
					Date o	of Symptoms	/illness start	=== ed	
Past Medical S	urgical History?		Yes	○ No	DD	MM	YYYY		
Obs/Gyn Claim	S						/illness start	ed	
Dara I	Gravida: A	B: LMP: M	larital Status:	Marital Date:	DD	MM	YYYY		
Pala	O Graviua.	B. LIVII . IVI	iaritai Status.	Iviantai Date.	$\dashv$				
What date did th	ne Patient first feel same / s	similar Symptom(s) : 0	dd mm yyyy						
Is the Patient un	nder any type of Treatment	? ○ Yes ○ No if	yes, indicate what	Assessment and since wh	en:				
OBJECTIVE / A	SSESSMENT(To be compl	eted by Physician)							
Clinical Finding			Vital Siç : 0	gns: B/P:112	T : 36.7	HR : 8	36	RR	
Assessment/Di	iagnosis : O Acute		Confirmed O	Suspected					
Туре		Code		Diagnosis					
Primary		R68.84					_		
Secondary		R52		Pain, unspecified					
ACCIDENT/OCC	CUPATIONAL Claim Inform	maton (complete if	claim is a result of	accident or work related	illness/ini	ury)			
	ness due to work?	Injury due to accident?	road	ibe how the accident or w			ss occur:		

Date of accident or beginning of illness:

 $\bigcirc$  Yes  $\bigcirc$  No

 $\bigcirc$  Yes  $\bigcirc$  No

Treatme	nt					Тур	2	Price	
GP Consultation								25.0000	
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular							ay ay	10.0000	
CLOFEN						Pha	rmacy	6.5000	
Code Generic				Duration	Instructions				
0278-107902-0391 (IBUPROFE		N : 400 MG) FILM COATED TABLETS		5	Take 1Tablets 2Tim	ne(s) perDa	e(s) perDay For 5 Day(s) after meal		
O Pharmacy:			Estmated Costs		aboratory / Radiology: Estmat		mated Costs		
		O Surgery:		O Endoscop	Endoscopy:				
Juired		O Physiotherapy:		Other Pro	ocedures:				
				If yes please specify					
d 2 Longth	f Cto	,		Indicate Prov	idor		Entin	nate Cost	
services sho	own c	on this form were	to release any for the purpo	/ informaton se of determi	regarding my medic ning insurance bene	al conditon	and history to	NEXtCARE	
lame : AHS	AN H	JSSAIN	,	.,					
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	6								
LC									
	GP Consultation of the con	Therapeutic, p subcutaneous CLOFEN  Generic (IBUPROFE)  de ? Length of State all information reservices shown of the experience of the exp	GP Consultation  Therapeutic, prophylactic, or diagnos subcutaneous or intramuscular  CLOFEN  Generic  GI (IBUPROFEN : 400 MG) FILM COAT  Estmated Costs  Surgery: Physiotherapy:  d? Length of Stay t all informaton mentoned are correct services shown on this form were d & necessary for the management of  Name: AHSAN HUSSAIN  :	GP Consultation  Therapeutic, prophylactic, or diagnostic injection (subcutaneous or intramuscular  CLOFEN  Generic  I (IBUPROFEN : 400 MG) FILM COATED TABLETS  Estmated Costs  Surgery: Physiotherapy:  I hereby auth to release any for the management of services shown on this form were and an ecessary for the management of services.  Also AHSAN HUSSAIN  I hereby auth to release any for the purporesponsibility.  I hame: AHSAN HUSSAIN  I hereby auth to release any for the purporesponsibility.	GP Consultation  Therapeutic, prophylactic, or diagnostic injection (specify substassibutaneous or intramuscular  CLOFEN  Generic  GI (IBUPROFEN : 400 MG) FILM COATED TABLETS  Estmated Costs  Surgery:  Physiotherapy:  Other Profit if yes please  GROWN Coaten in the purpose of determine the purpose of determine the purpose of determine the purpose of determine the purpose of determines to release any information for the purpose of determines the purpose of determines to release any information for the p	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  CLOFEN    Generic	GP Consultation  Generic  Generic  Duration  Instructions  GI  Generic  Generic  Duration  Instructions  Take 1 Tablets 2 Time(s) per Data (Surgery:  Other Procedures:  If yes please specify  d ? Length of Stay  Indicate Provider  to release any informaton regarding my medical condition for the purpose of determining insurance benefits. Medica responsibility of doctor and the patent.  Interest and the patent.  Generic  Duration Instructions  Take 1 Tablets 2 Time(s) per Data (Surgery:  Other Procedures:  If yes please specify  Indicate Provider  Intereby authorize any Healthcare Provider, Insurer, Emplot to release any informaton regarding my medical condition for the purpose of determining insurance benefits. Medica responsibility of doctor and the patent.	General Consultation  Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  CLOFEN  Pharmacy  Generic Duration Instructions  Take 1Tablets 2Time(s) perDay For 5 Day(s)  Estmated Costs  Laboratory / Radiology: Estmated Costs  Surgery: Estmated Costs  Surgery: Other Procedures: If yes please specify  d? Length of Stay Indicate Provider Estir to all information mentaned are correct services shown on this form were l& necessary for the management of responsibility of doctor and the patent.  I hereby authorize any Healthcare Provider, Insurer, Employer or other of the purpose of determining insurance benefits. Medical management responsibility of doctor and the patent.	

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

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 efects 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.

Note: Claims must be submited along with supporting documents within 30 days from date of service