**ADMINISTRATIVE** 

## **eASOAP FORM**



at the CITICARE MEDICAL CEN

Patent Name: MOHAMMED HUDAN AHAMED HOSSAIN			ender:	Male	Validity Between:	13/06	13/06/2024 and		
Card No:	792B-5FCF-2520-70	)7E D	ОВ:	12/10/1978 12:00:00 AM	Coverage Informaton for:	Out Patient			
Pin #:		Id	entty Card:		Network:		IAE (Al Ans GULF		
Natonal ID: Policy Holder:				Service Date: 22-Oct-2024 Radiology: Patent's Tel No: 0551138109 Threshold			red		
Payer Name:	ORIENT INSURANC P.J.S.C	`F	mit: ass:	Normal					
Category:	Category B	NO:				Co-Part: 20%			
Gatekeeper:	No	C	onsultaton :		Laboratory:	Cove	red		
Referral No: Referred Service:									
SUBJECTIVE AS	SESSMENT								
Symptom(s) as	described by the pate	ent (Chief	Complaint):			_	f Symptom		
Complaint						DD	MM		
PC: HYPERURI	ECEMIA IDEMIC KNOWN								
ON REGULA	R MEDICATION								
JOINTS PAIN									
			T			Date o	 of Symptom		
Past Medical Su	urgical History?			Yes	O No	DD	ММ		
Obs/Gyn Claims							of Symptom		
		7.0		Andrei Cinter	NA	DD	MM		
Para	Gravida:	AB:	LMP: N	1arital Status:	Marital Date:	-			
What date did th	e Patient first feel sam	e / similar S		dd mm yyyy	1	1			
					essment and since when	:			

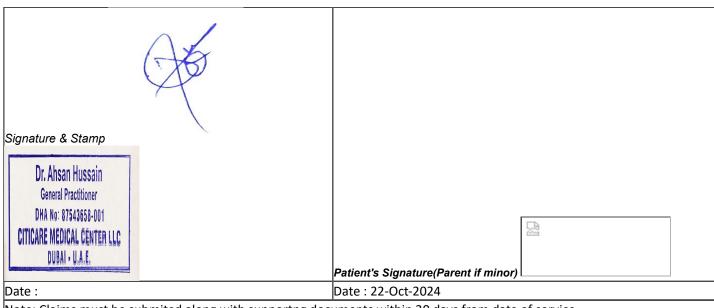
The member is allowed for **Out Patient** 

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## OBJECTIVE / ASSESSMENT(To be completed by Physician)

accident?  Yes No  No  Date of accident or beginning of illness:  MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider clater of the consultation of the consulta	Clinical Fi	indings :						Vital Signs∶ B/P∶ RR∶18	110	T:	36.6	HR	
Primary E78.5 Hyperlipidemia, unspecified Secondary E79.0 Hyperuricemia w/o signs of inflam arthrit and tophaceous dis Secondary J20.9 Acute bronchitis, unspecified Secondary E08.2.1 Diabetes due to underlying condition w diabetic nephropathy  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury) ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in to road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in to road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in to road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in to road accident or illness/injury)  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in to road accident or work related injury/in the paccident or work related injury/in to road accident or work related injury/in the paccident or work rel	Assessme				ronic	O Con	firme	d O Suspecte	d				
Secondary E79.0 Hyperuricemia w/o signs of inflam arthrit and tophaceous dis Secondary J20.9 Acute bronchitis, unspecified Secondary E08.21 Diabetes due to underlying condition w diabetic nephropathy  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury) Injury due to road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in road accident?  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/in related injury/in read accident or work related injury/in rel	Туре	Code Diagnosis											
Secondary   120.9   Acute bronchitis, unspecified   Secondary   E08.21   Diabetes due to underlying condition w diabetic nephropathy  ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury) Injury due to condition with accident or work related injury/injury due to condition with accident?    Open	Primary	mary E78.5 Hyperlipidemia, ur				specified	ł						
Diabetes due to underlying condition w diabetic nephropathy   Cacident or illness due to work?	Seconda	Secondary E79.0 Hyperuricemia w/o				signs of	infla	m arthrit and top	haceou	s dis			
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)    Injury due to road accident or illness due to work?   Injury due to road accident?	Secondary J20.9 Acute bronchitis, u				hitis, ur	nspecifie	d						
Accident or illness due to work?    Injury due to road accident?   Describe how the accident or work related injury/is accident?   O'Yes   O'Nes   O'N	Secondary E08.21 Diabetes due to un				e to un	derlying	cond	ition w diabetic n	ephrop	athy			
Accident or illness due to work?  to road accident?  Yes No  Date of accident or beginning of illness:  MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider class of the prescriptions of the presc	ACCIDEN1	r/occupati	ONAL Claim I	nformaton (con	nplete i	f claim i	s a re	sult of accident of	r work	related illi	ness/ii	njury)	
Date of accident or beginning of illness:  MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider class of the part of this case.  MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider class of the part	Accident or illness due to work?					to road		Describe how the accident or work related injury/illne					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider class of the following required or reading physician Name: AHSAN HUSSAIN  Type  Treatment  Type  General Consultation  General Consultation  Lab  Lab  Lab  Lab  Lab  Lab  Lab  La	O Yes	) No				_	0						
Type  General Consultation  General Consultation  General Consultation  Uric acid; blood  Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)  Lab  S2565 Creatinine; blood  Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)  Code  Generic  Duration  Instructions  No Prescriptions History Found  Pharmacy:  Estmated Costs  Surgery:  Chaboratory / Radiology:  Estmated Cost  Surgery:  Physiotherapy:  Other Procedures:  Physiotherapy:  If yes please specify  Indicate Provider  I hereby certfy that all informaton mentoned are correct at the medical services shown on this form were medically indicated & necessary for the management of this case.  Treating Physician Name: AHSAN HUSSAIN	Date of ac	ccident or be	eginning of illr	ness:									
General Consultation  General Consultation  General Consultation  General Consultation  General Consultation  Lab  S027 Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)  Lab  S2565 Creatinine; blood  Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)  Code  Generic  Duration  Instructions  No Prescriptions History Found  Pharmacy:  Estmated Costs  Surgery:  Surgery:  Chaboratory / Radiology:  Estmated Costs  Surgery:  Other Procedures:  If yes please specify  Indicate Provider  I hereby certfy that all informaton mentoned are correct at the medical services shown on this form were medically indicated & necessary for the management of this case.  Treating Physician Name: AHSAN HUSSAIN	MEDICAL	PLAN Itemiz	ed Original In	voices and Appl	licable F	Prescript	ions ,	/ Reports / Result	s must	be enclose	d to co	onsider claim	
Source   Consultation   Consultation		Treatment										Туре	
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)   Lab	9	GP Consultation										General Consultation	
Lab   Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)   Lab	84550	Uric acid; blood										Lab	
Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)  Code  Generic  Duration  Instructions  No Prescriptions History Found  Pharmacy:  Estmated Costs  Surgery:  Physiotherapy:  Other Procedures:  If yes please specify  Indicate Provider  I hereby certfy that all informaton mentoned are correct at that the medical services shown on this form were medically indicated & necessary for the management of this case.  Treating Physician Name: AHSAN HUSSAIN	85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and p							ount)			Lab	
Code Generic Duration Instructions  No Prescriptions History Found  Pharmacy: Estmated Costs Cathering Physiotherapy: Other Procedures:  If yes please specify  Indicate Provider  Intereby certfy that all informaton mentoned are correct at that the medical services shown on this form were medically indicated & necessary for the management of his case.  Duration Instructions  Instructions  Laboratory / Radiology: Estmated Cost  Other Procedures:  If yes please specify  Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer or release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical management of responsibility of doctor and the patent.  Treating Physician Name: AHSAN HUSSAIN	82565	Creatinine; blood										Lab	
No Prescriptions History Found  Pharmacy: Estmated Costs O Laboratory / Radiology: Estmated Cost  Surgery: O Endoscopy: O Other Procedures: Physiotherapy: If yes please specify  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 release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managements of responsibility of doctor and the patent.  I reating Physician Name: AHSAN HUSSAIN	80061					•					in,	Lab	
No Prescriptions History Found  Pharmacy:  Estmated Costs  O Laboratory / Radiology:  Estmated Cost  O Surgery: O Endoscopy: O Other Procedures: Physiotherapy: If yes please specify  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.  Treating Physician Name: AHSAN HUSSAIN  Estmated Cost  I Laboratory / Radiology:  Estmated Cost  I Laboratory / Radiology: Estmated Cost  I Laboratory / Radiology:  Estmated Cost  I Laboratory / Radiology:  Estmated Cost  O Laboratory / Radiology:  Estmated Cost  I Laboratory / Radiology:  Estmated Cost  O Laboratory / Radiology:  O Laboratory / Radiology:  Estmated Cost  O Laboratory / Radiology:  Estmated Cost  O Laboratory / Radiology:  O Laboratory / Rad												,	
Surgery: Estmated Costs  Surgery: Other Procedures:  If yes please specify  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.  Interesting Physician Name: AHSAN HUSSAIN  Surgery: Other Procedures:  I hereby authorize any Healthcare Provider, Insurer, Employer or release any informaton regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.	Code Generic				Duration				Instructions				
Surgery: Onther Procedures:  Physiotherapy: Other Procedures:  If yes please specify  Indicate Provider  I hereby certfy that all informaton mentoned are correct at the medical services shown on this form were medically indicated & necessary for the management of this case.  In hereby authorize any Healthcare Provider, Insurer, Employer or release any informaton regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.  In hereby authorize any Healthcare Provider, Insurer, Employer or release any information regarding my medical condition and history that the purpose of determining insurance benefits. Medical management of the purpose of doctor and the patent.	No Presci	riptions Hist	ory Found							I			
If yes please specify  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.  Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer or release any informaton regarding my medical condition and history the purpose of determining insurance benefits. Medical management of this case.  Indicate Provider	O Pharm	пасу:		Estmated Costs	tmated Costs			O Laboratory /	_aboratory / Radiology:			Estmated Costs	
If yes please specify  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.  Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer or release any informaton regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.  Indicate Provider				3	O Sur	rgery:	OE	Endoscopy:					
Indicate Provider  I hereby certfy that all information mentioned are correct that the medical services shown on this form were medically indicated & necessary for the management of this case.  Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer or release any information regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.  Indicate Provider	Is the following required				O Physiot	therapy:	00	Other Procedures	ocedures:				
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 release any informaton regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.  Treating Physician Name: AHSAN HUSSAIN							If ye	s please specify					
that the medical services shown on this form were medically indicated & necessary for the management of this case.  Treating Physician Name: AHSAN HUSSAIN  release any information regarding my medical condition and history the purpose of determining insurance benefits. Medical management of responsibility of doctor and the patent.	s In-patier	nt Required ?	Length of Sta	у				Indicate Provider					
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iei / i ax (iiiipoitalit).			ne : AHSAN H	USSAIN									
	iei / rax (I	mportant).											

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Note: Claims must be submited 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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NEX no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the N doctors.

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