eASOAP FORM

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

Patent Name:	**IMAN GHULOOM AHMAD HASSAN ALBLOOSHI**	Gender:	**Female**	Validity Between:	**01/01/2024 and 3**
Card No:	**1EF1-BB4C-3D32-3115**	DOB:	**7/19/1985 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1985-7249424-7**	Service Date:	**28-Oct-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0508700446**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40082**	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**	
	DD	MM
Complaint PC: Recurrent low back pain, that radiates to both lower limb associated with numbness and tingling sensation. Duration: 1week. (current episode) Pain is cored 7/10.		

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 : 90 T : 36.6 HR : RR : 18

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

Type	Code	Diagnosis
Primary	M54.32	Sciatica, left side
Secondary	M54.5	Low back pain
Secondary	R20.2	Paresthesia of skin
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

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

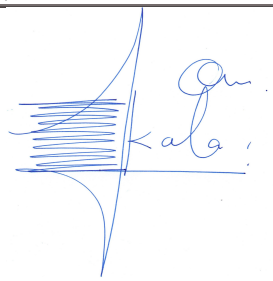
CPT Code	Treatment	Type
9	GP Consultation	General Consultation
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
0005-149902-1021	CLOFEN	Pharmacy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay

Code	Generic	Duration	Instructions
0188-232401-0393	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day Fo evening
0005-106601-0052	(PARACETAMOL : 500 MG) CAPLETS	4	Take 2Tablets 3 Time(s) per Day Fo meal
0027-149903-2231	(DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES	5	Take 1Tablets 1 Time(s) per Day Fo evening
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	15	Take 1Tablets 2Time(s) perDay For 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* 	***Patient's Signature(Parent if minor)***
Date :	Date : 28-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.