ADMINISTRATIVE

eASOAP FORM



at the CITICARE MEDICAL CEN

Patent Name:	Faria Sabir Sabir H	ussain Ge	ender:	Female	Validity Between:	20/07/	2024 and 1
Card No:	DF13-81C6-2A6C-C	391 DO	OB:	7/10/1996 12:00:00 AM	Coverage Informaton for:	Out P	atient
Pin #:		Id	entty Card:		Network:	RN U	AE (Al Ansa GULF
Natonal ID:	784-1996-6604380-9	Pa		07-Nov-2024 : 0524547324	Radiology:	Cover	red
Policy Holder:			nreshold mit:				
Payer Name:	MetLife	Cl	ass:	Normal			
Category:	Category B		ut-Patent : atent's File	43587	Pharmacy:	Co-Pa	rt: 20%
Gatekeeper:	No		onsultaton :		Laboratory:	Covered	
Referral No: Referred Service:							
SUBJECTIVE ASS	described by the pate	ent (Chief	Complaint):			Date of	f Symptom
Complaint						DD	MM
No Complaints	Found for Selected A	ppointmei	nt				
Past Medical Su	rgical History?		○ Yes		ONo	Date of Symptom	
- use ivicultur su	ingicui i iistory.				0 140	DD	MM
Obs/Gyn Claims	:					Date o	f Sympton
						100	0 40 4
·			I I		T	DD	MM
·		AB:	LMP: M	arital Status:	Marital Date:	UU	IVIVI
Para [Gravida:				Marital Date:	- DD	MIM
Para C	Gravida:	e / similar S	Symptom(s) : c	dd mm yyyy			IMIM
Para What date did the	Gravida: e Patient first feel same der any type of Treatme	e / similar S	Symptom(s) : ces No if	dd mm yyyy	Marital Date:		MM
Para What date did the	Gravida: e Patient first feel same der any type of Treatme SSESSMENT(To be con	e / similar S	Symptom(s) : ces No if	dd mm yyyy	essment and since when	n:	
Para What date did the ls the Patient und OBJECTIVE / AS Clinical Finding Assessment/Dia	Gravida: Patient first feel same der any type of Treatmeter and typ	e / similar Sent? Ye	Symptom(s): ces No if Physician) Chronic	dd mm yyyy yes, indicate what Ass Vital Signs : RR :	essment and since when	n:	HR:
Para What date did the ls the Patient und OBJECTIVE / AS Clinical Finding Assessment/Dia	Gravida: e Patient first feel same der any type of Treatme SSESSMENT(To be constitutions) s:	e / similar Sent? Yes	Symptom(s): ces No if Physician) Chronic	dd mm yyyy yes, indicate what Ass Vital Signs : RR :	sessment and since when	n:	

The member is allowed for **Out Patient**

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llir	nicSo	ft 8.	0 -	NextCare	Form

& that the medical services shown on this form were release any informaton regarding my medical conditon and history	ACCIDENT/OCCU	PATIONAL Claim I	nformaton (complete	if claim is a re	esult of accident or we	ork related illn	ess/injury)	
Date of accident or beginning of illness: Mo	Accident or illness due to work?			to road	Describe how the ac	scribe how the accident or work related injury/illr		
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim CPT Code Treatment Type 9	O Yes O No							
CPT Code Treatment Type	Date of accident of	or beginning of illr	ness:]			
9 GP Consultation 84443 Thyroid stimulating hormone (TSH) 83002 Gonadotropin; luteinizing hormone (LH) 83001 Gonadotropin; follicle stimulating hormone (FSH) Lab Code Generic Duration Instructions No Prescriptions History Found Pharmacy: Estmated Costs OLABORATORY / Radiology: Estmated Costs Surgery: OEndoscopy: Is the following required 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 information regarding my medical condition and history and this case. Treating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Signature & Stamp D. Alsa Hussain Grad Phabbur DIA Fax (important): Patient's Signature(Parent if minor) Date: Date: O7-Nov-2024	MEDICAL PLAN Ite	emized Original In	voices and Applicable	Prescriptions	/ Reports / Results mu	ust be enclosed	d to consider claim	
Surgery: Candot Provider Costs	CPT Code	Treatment	Treatment Type					
Surgery: Endoscopy: If yes please specify Sethated Costs Indicate Provider Indicate & necessary for the management of this case. Signature & Stamp Dr. Missi Hussin General Robinship (Important): Patient's Signature (Parent if minor) Pate: Date: D	9	GP Consultation	1			General Consultation		
Code Generic Duration Instructions No Prescriptions History Found Pharmacy: Estmated Costs	84443	Thyroid stimula	ting hormone (TSH)		Lab			
Code Generic Duration Instructions No Prescriptions History Found Pharmacy: Estmated Costs	83002	Gonadotropin; I	uteinizing hormone (L	.H)		Lab		
No Prescriptions History Found Pharmacy: Estmated Costs Surgery: Physiotherapy: Other Procedures: If yes please specify 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. Treating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Signature & Stamp Di. Alsan Hussain General Practions Phile 11-1456-1011 Contact Provider I hereby authorize any Healthcare Provider, Insurer, Employer or other release any information regarding my medical condition and history the purpose of determining insurance benefits. Medical management responsibility of doctor and the patent. Teating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Patient's Signature(Parent if minor) Date: Date: O7-Nov-2024	83001	Gonadotropin;	follicle stimulating hor	mone (FSH)		Lab		
No Prescriptions History Found Pharmacy: Estmated Costs Surgery: Physiotherapy: Other Procedures: If yes please specify 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. Treating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Signature & Stamp Di. Alsan Hussain General Practions Phile 11-1456-1011 Contact Provider I hereby authorize any Healthcare Provider, Insurer, Employer or other release any information regarding my medical condition and history the purpose of determining insurance benefits. Medical management responsibility of doctor and the patent. Teating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Patient's Signature(Parent if minor) Date: Date: O7-Nov-2024	Code	Generic		Duration		Instruction	inc	
Pharmacy: Surgery: Endoscopy:				Daracion		mstructio		
Is the following required Physiotherapy: Other Procedures: If yes please specify	-	Thotally Found	Estmated Costs		C Laboratory / Rad	iology:	Estmated Costs	
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 Tel / Fax (important): Signature & Stamp Dr. Ahsan Hussain General Practitioner DNA No: UTLARE MEDICAL CENTER LC DUBAL-LARE. Patient's Signature(Parent if minor) Date: Date: 07-Nov-2024	Is the following required			otherapy:	Other Procedures:			
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: AHSAN HUSSAIN Tel / Fax (important): Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 8754865-001 CTICARE MEDICAL CENTER LCC DUSAI-UALE. Patient's Signature(Parent if minor) Date: Date: Date: 07-Nov-2024	ls In-patient Requir	ed ? Length of Sta	у		Indicate Provider			
Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date: 07-Nov-2024	& that the medical services shown on this form were medically indicated & necessary for the management of this case.			release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managemen				
Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: 07-Nov-2024	Tel / Fax (important	t):						
Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: 07-Nov-2024	Signatura & Stampa							
	Dr. Ahsan Hussain General Practitioner Dha No: 87543658-001 CITICARE MEDICAL CENTER			Patient's Sign				
Note: Claims must be submited along with supporting documents within 30 days from date of service	Date :			Date : 07-No	v-2024			
	Note: Claims must	t be submited alo	ng with supportng do	cuments withi	n 30 days from date o	f service		

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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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