eASOAP FORM

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

Patent Name:	**EYERUSALEM GETACHEW BEKELE**	Gender:	**Female**	Validity Between:	**26/04/2024 and (**
Card No:	**67FB-585E-745A-5B5F**	DOB:	**9/12/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1990-7273505-5**	Service Date:	**19-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0526994586**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44952**	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**	
Complaint						DD	MM
co joint pain pallor from 1 month oct 2024 oe chest is clear no added sounds restless							
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 : 120 T : 36.5 HR : RR : 18

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

Type	Code	Diagnosis
Primary	D64.9	Anemia, unspecified
Secondary	M25.449	Effusion, unspecified hand

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
83550	Iron binding capacity	Lab
83540	Iron	Lab
86431	Rheumatoid factor; quantitative	Lab
84550	Uric acid; blood	Lab

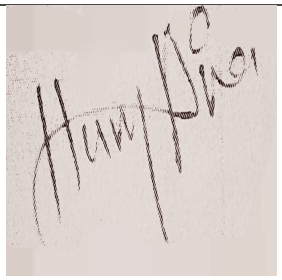
Code	Generic	Duration	Instructions
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	1	Take 1Gel 1Time(s) perDay For 1 Day
0278-107903-0391	(IBUPROFEN : 600 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3

○ 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 : **Humaira**	
Tel / Fax (important):	

Signature & Stamp  	***Patient's Signature(Parent if minor)***
Date :	Date : 19-Nov-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
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doctors.