ADMINISTRATIVE

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The member is allowed for Out Patient

at the CITICARE MEDICAL CENTER LLC

Pin #: Identty Card: Network: Network: NETWORK											
Prin d: Identity Card: Network: MEDGUIF National ID: 784-1997-26249644 Service Date: 19-Nov-2024 Radiology: Covered Patent's Tel No: 0553303607 Threshold Limit: Payer Name: Payer Name: ORIENT INSURANCE Class: Normal Category: Category B Patent's File 44948 Pharmacy: Co-Part: 20% Category: Category B No: Consultation: Laboratory: Covered Referral No: Referral No: Referred Service Service Service Date: 19-No Patent's File 44948 Pharmacy: Co-Part: 20% Referral No: Referred Service: Date of Symptoms/fillness started Complaint No Complaints Found for Selected Appointment Past Medical Surgical History? Yes No Do MM NYYY Obs/Gyn Claims Obs/Gyn Claims Obs/Gyn Claims What date did the Patient first feel same / similar Symptom(s): dd mm yyyy Is the Patient under any type of Treatment? O'yes No If yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT IT To be completed by Physicians Clinical Findings: Acute Octobro Symptoms Type Code Diagnosis Primary 10.2.9 Acute Patryrights, unspecified Secondary N79.10 Mysigis, unspecified	Patent Name: KORDI HOUSSEN AL			ender:	Female	Validity Between:	15/01/20	15/01/2024 and 14/01/2025			
National ID: 784-1997-2624964-4 Service Date: 19-Nov-2024 Radiology: Covered Patent's Tel No: 0553303607 Threshold Limit: Payer Name: ORIENT INSURANCE P.J.S.C Class: Normal Out-Patent: File 4948 Pharmacy: Co-Part: 20% Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referral No: Referral No: Referral No: Service Assessment Service: SubJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illiness started Complaint Date of Symptoms/illiness started Obs/Gyn Claims Pate of Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Date of Symptoms/illiness started DD MM	Card No:	3F9A-E639-5405-5E	:02 D	ОВ:		-	Out Pat	Out Patient			
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Secondary J11.1 Flu due to unidentified influenza virus w oth resp manifest	Secondary	M79.10	Myal	gia, unspecifi	ed site						
	Secondary	R50.9	Fever	, unspecified							
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)	Secondary	J11.1	Flu d	ue to unident	ified influenza virus v	v oth resp manifest					
	ACCIDENT/OCC	CUPATIONAL Claim Inf	ormaton	(complete if	claim is a result of ac	cident or work related il	lness/iniur	v)			

Accident or illness due to work? Injury due accident?				o road Describe how the accident or wo		ent or work	k related injury/illness occur:			
○ Yes ○ No ○ Yes				○Yes ○ No						
Date of accident or begin										
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim										
CPT Code	Treatmer	nt				Туре			Price	
9.01	Follow-up	o consultati	on		General Consultation				0.0000	
Code	Generic			Duration	Duration Instruction			ons		
No Prescriptions History	Found									
O Pharmacy:		Estmated	Costs		O Laboratory / Radiology:			Estmated Costs		
○ Sı			urgery:		0	O Endoscopy:				
Is the following required		OPhysio		Other Procedures:						
				If yes please specify						
Is In nationt Paguired 2 Lo	nath of Stay	,			Indicate Provider			Estimate Cost		
	Is In-patient Required? Length of Stay Indicate Provider Estimate Cost I hereby certfy that all information mentioned are correct I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization									
& that the medical service										
& that the medical services shown on this form were medically indicated & necessary for the management of for the purpose of determining insurance benefts. Medical management is the sole										
this case.	responsibility	of d	octor and the paten	t.						
Treating Physician Name :	Enomen G	oodluck								
Tel / Fax (important):	1									
Signature & Stamp										
Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.				(Parent if minor)						
Date :				Date : 19-No						
Note: Claims must be sub	mited alor	ng with sup	portng docu	ıments withir	1 30 c	days from date of se	rvice			

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.