eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the CITICARE MEDICAL CENTER LLC

Patent Name:	ABDUL JOHIR KOLOMDOR ALI	Gender:	Male	Validity Between:	26/08/2	024 and 25/0	8/2025		
Card No:	FBAB-0A2D-AD3A-B836	DOB:	8/20/1978 12:00:00 AM	Coverage Informaton for:	Out Pa	tient			
Pin #:		Identty Card:		Network:	RN UAI	E (Al Ansari- <i>i</i> JLF	AUH)-		
Natonal ID:	784-1978-4627061-5	Service Date:	21-Nov-2024	Radiology:	Covere	d			
		Patent's Tel No:	971501644994						
Policy Holder:		Threshold Limit:							
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal						
		Out-Patent :							
Category:	Category B	Patent's File No:	38709	Pharmacy:	Co-Par	t: 20%			
Gatekeeper:	No	Consultaton :		Laboratory:	Covere	d			
Referral No:									
Referred									
Service:									
SUBJECTIVE ASSESSMENT									
Symptom(s) as	described by the patent (Ch	nief Complaint):			Date of	Symptoms/il	Iness started		
Complaint					DD	MM	YYYY		

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/Illness started						
Complaint							DD	ММ	YYYY			
For follow up Unable to commence medications because insurance rejected augmentin												
							Date of Symptoms/illness started					
Past Medica	al Surgical History?	○Yes		() No				YYYY				
				•								
Obs/Gyn Cla	aims							Date of Symptoms/illness started				
Obs/Gyll Cla	311112							DD	MM	YYYY		
☐ Para	☐ Gravida:	□ АВ:	LMP:	Marital Status: Ma		Marital Date:						
	id the Patient first feel s		• • •									
Is the Patien	t under any type of Trea	atment? O Ye	es O No	if yes, indicat	e what Asses	ssment and since	when:					
OBJECTIVE	/ ASSESSMENT(To be	completed by	Physician	1)								
Clinical Findings: Vital Signs: B/P:130 T:3							T : 30	5.3	HR : 92	RR		
	t/Diagnosis : O A INDICATE DIAGNOSIS		Chronic OM	O Confirme	d O Susp	ected						
Туре	Co	de	D	Diagnosis								
Primary	LO	L02.31 Cu			Cutaneous abscess of buttock							
Secondary L02.415 Cut			Cutaneous abscess of right lower limb									
Secondary	/ R5	0.9	Fever, unspecified									
1										l		

Type

Type Code				Diagnosis									
Secondary M79.10 Mya			Myalgia, unsp	algia, unspecified site									
ACCIDENT/OCCUP	ATIONAL	Claim I	nformaton	(comple	ete if claim is	a res	ult of accid	ent or work	related illn	ess/injury)			
Accident or illness due to work? Injury due to accident?				due to road nt?	Describe how the accident or work related				related inju	ry/illness occur:			
○ Yes ○ No				○ No									
Date of accident or beginning of illness:													
MEDICAL PLAN Itemized Original Invoices and Applicable P					ble Prescriptio	ons /	Reports / R	esults must	be enclosed	to conside	r claim		
CPT Code Treatment					Туре					Price			
9		GP Co	nsultation			Ger	neral Consu	ltation			25.0000		
Code	Code Generic						Duration Instructions			าร	s		
0152-116604- 0391	(METRONIDAZOLE : 500 MG EILM CO.					ATED TABLETS				ake 1Tablets 2 Time(s) per Day For 10 ay(s) after meal			
0097-116206- 0391	(AMOXICILLIN: 875 MG (CLAVULANIC COATED TABLETS					ACID: 125 MG FILM 7 Take 1Tablets 2T after meal					ts 2Time(s) perDay For 7 Day(s)		
O Pharmacy:			Estmated	Costs			O Laboratory / Radiology: Estmat				Costs		
○ Surgery:						○ Endoscopy:							
Is the following red	quired		O Physiotherapy:			\rightarrow	Other Procedures:			1			
			, , ,				If yes please specify			1			
la la nationt Docuire	Is In-patient Required ? Length of Stay						Indianta Dra	vidos			Estimate Cost		
I hereby certfy that				ire corre	ect I hereby o	Indicate Provider Estimate Cost I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton							
& that the medical services shown on this form were			to release	to release any informaton regarding my medical conditon and history to NEXtCARE									
				for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.									
this case. Treating Physician Name : Enomen Goodluck					responsit	Jility	oj doctor di	ia trie pater	π.				
Tel / Fax (important):													
Signature & Stamp													
Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC													

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 fnal opinion will be given by the NEXtCARE claims doctors.

Date: 21-Nov-2024

Note: Claims must be submited along with supporting documents within 30 days from date of service

Patient's Signature(Parent if minor)

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