eASOAP FORM

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

Patent Name:	**Omar Ahmad Almheiri**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**34A2-10AC-62EA-FE9D**	DOB:	**7/8/1994 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1994-3276030-6**	Service Date:	**22-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0553993874**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44386**	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 Symptoms/illness started		
	DD	MM	YYYY
Complaint pc: pain in left hand and forearm 21/11/2024 got operated for the same arm in 2018 due to accident pain also in knees both since yesterday flu runny nose			

Past Medical Surgical History?	○ Yes	○ No	Date of Symptoms/illness started		
			DD	MM	YYYY

Obs/Gyn Claims						Date of Symptoms/illness started		
						DD	MM	YYYY
☐ 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 : 130 T : 36.5 HR : 64 RR : 16

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	M25.561	Pain in right knee
Secondary	M79.602	Pain in left arm
Secondary	M62.81	Muscle weakness (generalized)
Secondary	J06.9	Acute upper respiratory infection, unspecified

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/illness occur:
○ 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	Price
9	GP Consultation	General Consultation	25.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000

Code	Generic	Duration	Instructions
0005-128802-1971	(XYLOMETAZOLINE HYDROCHLORIDE : 0.1% LIQUID FOR SPRAY (NASAL	7	Take 1Spray 2 Time(s) per Day For 7 Day(s) others
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

○ 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	Estimate Cost
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 other Organizaton 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.*	
Treating Physician Name : **AHSAN HUSSAIN**		
Tel / Fax (important):		
Signature & Stamp 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 : 22-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 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.