eASOAP FORM

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

Patent Name:	**Yelyzaveta Cherevko**	Gender:	**Female**	Validity Between:	**23/11/2024 and 30/09/2025**
Card No:	**B384-F17D-6AA9-73BE**	DOB:	**5/16/2003 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2003-9460468-8**	Service Date:	**07-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0553455631**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45148**	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**		
Complaint Swelling and pain on both big toes. infected and oozing pus Duration: 2weeks	DD	MM	YYYY

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 : 116 T : 36.8 HR : 78 RR : 18

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

Type	**Code**	**Diagnosis**
Primary	L03.031	Cellulitis of right toe
Secondary	L03.032	Cellulitis of left toe
Secondary	R52	Pain, 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
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;	Co.Pay	75.0000

Code	Generic	Duration	Instructions
0005-106601-1171	(PARACETAMOL : 500 MG TABLETS	4	Take 1Tablets 3 Time(s) per Day For 4 Day(s) after meal
0027-142201-2401	(DICLOFENAC POTASSIUM : 50 MG) SUGAR COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal

○ 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 : **Enomen Goodluck**		
Tel / Fax (important):		
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 07-Dec-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.