eASOAP FORM

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

Patent Name:	**Faria Sabir Sabir Hussain**	Gender:	**Female**	Validity Between:	**20/07/2024 and 19/07/2025**
Card No:	**DF13-81C6-2A6C-C391**	DOB:	**7/10/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-6604380-9**	Service Date:	**12-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0524547324**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MetLife**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43587**	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 PC: Painful swelling at the occipital region of the skull. Duration: recurrent. current episode = 4days. Exam: hyperemic, flunctuant and markedly tender. Incision and drainage is advised. For FBS 8am tomorrow	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 : 110 T : 38.8 HR : 98 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	L02.811	Cutaneous abscess of head [any part, except face]

Type	Code	Diagnosis
Secondary	L03.811	Cellulitis of head [any part, except face]

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
9.01	Follow-up consultation	General Consultation	0.0000
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	Co.Pay	75.0000

Code	Generic	Duration	Instructions
0027-142201-2401	(DICLOFENAC POTASSIUM : 50 MG) SUGAR COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0138-169101-1451	(DOXYCYCLINE : 100 MG CAPSULES (HARD GELATIN	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) after meal
3114-671601-1451	(CEFALEXIN : 500 MG CAPSULES (HARD GELATIN	7	Take 1Tablets 3Time(s) perDay For 7 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 : 12-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

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