

eASOAP FORM


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

Patent Name:	HAMAD ALI HASSAN ABDULLA	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	4C51-F165-528E-9661	DOB:	12/16/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1987-8291726-8	Service Date:	13-Dec-2024	Radiology:	Covered
		Patent's Tel No:	0507099963		
Policy Holder:		Threshold Limit:			
Payer Name:	DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	45212	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: Pain on defecation Duration: recurrent for many months. There is no bleeding nor protrusion of the rectum. Requesting sick leave on account of the pain						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 : 120 : 18	T : 36.8	HR : 84	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K64.9	Unspecified hemorrhoids
Secondary	K62.89	Other specified diseases of anus and rectum

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

Code	Generic	Duration	Instructions
0071-158501-0391	(HESPERIDIN : 50 MG (DIOSMIN (FLAVONOIDIC FRACTION : 450 MG FILM COATED TABLETS	15	Take 1Tablets 2Time(s) perDay For 15 Day(s) after meal
0027-149903-2231	(DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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

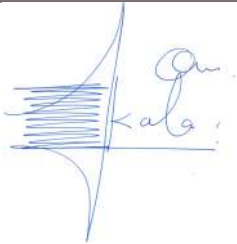
I hereby certify that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

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 benefets. Medical management is the sole responsibility of doctor and the patent.

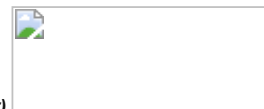
Treating Physician Name : **Enomen Goodluck**

Tel / Fax (important):

Signature & Stamp




Patient's Signature(Parent if minor)



Date :

Date : 13-Dec-2024

Note: Claims must be submitted along with supporting 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.