

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	IFRAH HUSSAIN SOHEB HUSSAIN	Gender:	Female	Validity Between:	26/12/2024 and 25/12/2025
Card No:	1B86-9A12-2183-4CF6	DOB:	8/28/2015 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2015-7108468-6	Service Date:	30-Dec-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	552603633		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	29476	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

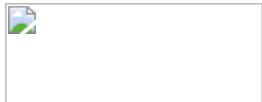
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
For follow up								
Has improved tremendously and has no complaint.								
No longer vomiting and cough is slight								
Mother is however requesting referral to ENT for further evaluation of her recurrent itchy ears and upper respiratory track infection.								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	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 : T : HR : RR :			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J03.90	Acute tonsillitis, unspecified					
Secondary	R11.10	Vomiting, unspecified					
Secondary	R05	Cough					

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	
No Prescriptions History Found				
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:	
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 : 30-Dec-2024		
Note: Claims must be submitted 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 effects 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.