eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**JOEL BAILLESTEROS**	Gender:	**Male**	Validity Between:	**29/08/2024 and 28/08/2025**
Card No:	**DFE6-A3F0-E4FD-27D9**	DOB:	**11/4/1988 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1988-5247368-9**	Service Date:	**30-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0585980411**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Islamic Arab Insurance Co. (P.S.C.**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42110**	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 Pain on defecation, and blood on stool. Duration: 1day Has a history of similar symptoms 6months ago. does not take tobacco and does not take alcohol known hypertensive on coveram and concord but not diabetic.			

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 : 126 T : 36 HR : 62 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K64.9	Unspecified hemorrhoids
Secondary	K60.0	Acute anal fissure
Secondary	R52	Pain, unspecified
Secondary	K29.71	Gastritis, unspecified, with bleeding

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

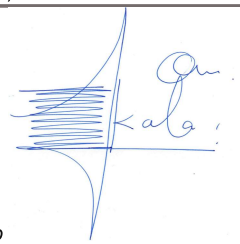
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000

Code	Generic	Duration	Instructions
0188-232401-0391	(ESOMEPRAZOLE : 40 MG FILM COATED TABLETS	14	Take 1Tablets 1Time(s) perDay For 14 Day(s) before meal
0071-158501-0391	(HESPERIDIN : 50 MG (DIOSMIN (FLAVONOIDIC FRACTION : 450 MG FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0183-142201-2401	(DICLOFENAC POTASSIUM : 50 MG) SUGAR COATED TABLETS	1	Take 1Tablets 2Time(s) perDay For 1 Day(s) after meal
0016-119401-2231	(ZINC OXIDE : 296 MG) (BALSAM PERUVIAN SINE RESINA : 49 MG) (BISMUTH OXIDE : 24 MG) (BISMUTH SUBGALLATE : 59 MG) RECTAL SUPPOSITORIES	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening
0027-149903-2231	(DICLOFENAC SODIUM : 100 MG) RECTAL SUPPOSITORIES	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening

○ 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* 	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 30-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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