

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	ARUNA PRABATH THILAKARATHNA SINGH RATHNA	Gender:	Male	Validity Between:	22/07/2024 and 21/07/2025
Card No:	F88C-8902-532E-17B6	DOB:	12/29/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
National ID:	784-1987-6293586-8	Service Date:	02-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0529642078		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44342	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: pain in throat, difficulty swallowing and headache, does not smoke and does not take alcohol. known diabetic on janumet and glibenclamide also taking cholestoerol medicine						DD	MM	YYYY
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 18	T : 36.7	HR : 84	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	E11.9	Type 2 diabetes mellitus without complications
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	K29.70	Gastritis, unspecified, without 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:		

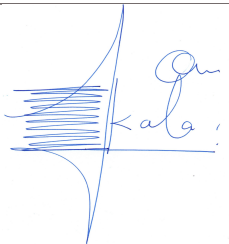
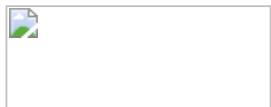
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000

Code	Generic	Duration	Instructions
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	6	Take 1Tablets 1 Time(s) per Day For 6 Day(s) after meal
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	4	Take 1Tablets 2 Time(s) per Day For 4 Day(s) after meal
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	7	Take 10ML 2 Time(s) per Day For 7 Day(s) after meal
0252-389902-1171	(LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal

☐ 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>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>		
<i>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.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 02-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

Disclaimer: NEXtCARE ASOAP form is used for claim creation 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 final opinion will be given by the NEXtCARE claims doctors.