## **eASOAP FORM**



**ADMINISTRATIVE** 

The member is allowed for **Out Patient** 

at the CITICARE MEDICAL CENTER LLC

Patent Name: **Omar Ahmad Almheiri** Gender: Male Validity Between: 01/01/2024 and 31/12/2026 **Coverage Information** 7/8/1994 12:00:00 Card No: 34A2-10AC-62EA-FE9D DOB: **Out Patient** AM for: RN UAE (Al Ansari-AUH)-Identty Card: Pin #: Network: **MEDGULF** 784-1994-3276030-6 09-Jan-2025 Radiology: National ID: Service Date: Covered Patent's Tel No: 0553993874 Threshold Policy Holder: Limit: Payer Name: **ENAYA** Class: Normal Out-Patent: Patent's File Pharmacy: Category: **Category B** 44386 Co-Part: 20% No: Gatekeeper: Laboratory: No Consultation: Covered Referral No: Referred Service:

## **SUBJECTIVE ASSESSMENT**

Symptom(s) as described by the patent (Chief Complaint):	lescribed by the patent (Chief Complaint): Date of Symptoms		illness started	
Complaint	DD	MM	YYYY	
PC: Right kneel pain, also pain on the shoulders and back				
said to be worst when heavy lifting at work				

ClinicSoft 8.0 -	NextCare	Form
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Past Medical Surgical History?		Voc			ONo	Date o	Date of Symptoms/illness started				
Past Medical Su	est ividuical Julgical mistory?		O Yes			ONo	DD	MM	YYYY		
Obs/Gyn Claims	;										/illness started
								tal Date:	DD	MM	YYYY
Para	Gravida	:	AB:	LMP:	Marital St	atus:	_				
What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy											
							<b>A</b>				
ls the Patient und	der any typ	e of Treat	ment? O ye	S O NO	if yes, inc	alcate what i	Assessme	nt and since who	en:		
OBJECTIVE / AS	SSESSME	NT(To be	completed by	Physician)							
Clinical Finding	s :					Vital Sigr RR : 18	ns: B/P:	138 7	T:36	HR:	87
Assessment/Dia	agnosis : ICATE DIA	O A	cute C	Chronic DM	O Conf	firmed C	Suspect	ed			
Туре		Code		Diagn	osis						
Primary		M17.1	12	Unilat	eral prima	ry osteoarth	ritis, left l	rnee			
Secondary		R52		Pain,	unspecified	ł					
Secondary		M54.5	5	Low b	ack pain						
ACCIDENT/OCC	UPATION	AL Claim I	nformaton (	complete	if claim is	a result of a	ccident o	r work related i	llness/inju	ry)	
Accident or illness due to work?  Injury due to road accident?  Describe how the accident or work related injury/illness occurred accident?					s occur:						
O Yes O No	res O No O Yes O No										
Date of accident	t or begin	ning of illi	ness:								
MEDICAL PLAN	Itemized (	Original Ir	voices and A	pplicable	Prescription	ons / Report	s / Results	must be enclos	ed to cons	sider claim	
CPT Code		Treatm	ent			Туре	oe I			Price	
9 Consultation GP				General Consultation 60.0000					00		
Code	G	Generic					Duration	n Instructions	tructions		
1217-373201-2401 (TOLPERISONE : 150 MG) SUGAR COATED TABLETS				ABLETS	15	Take 1Tablet after meal	ke 1Tablets 2 Time(s) per Day For 15 Day(s) ter meal				
0027-142201-	_/ IX _ / ` `	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION				R FOR	5	Take 1Powde	Take 1Powder 2 Time(s) per Day For 5 Day(s) after meal		

Code	Generic					Duration	Instructions		
0005-119803-1171	(PREDNISOI	REDNISOLONE : 20 MG) TABLETS			7	Take 1Tablets 1Time(s) perDay For 7 Day(s) after meal			
O Pharmacy:	Estmated Costs			O Lab	aboratory / Radiology: Estn		Estmated Costs		
Is the following required		O Surgery:	O E	Endoscopy:					
		O Physiotherapy:	Other Procedures:						
			If yes please specify						

ls 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 Healthcard to release any informaton regard for the purpose of determining in responsibility of doctor and the p	istory to NEXtCARE		
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 : 09-Jan-2025			
Note: Claims must be submited along with supportng doc	cuments within 30 days from date	of service		
isolainaan NEV+CARE ACOAR forms is used for plains areat	an number of the data contained b		and NEVACAE	

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 final opinion will be given by the NEXtCARE claims doctors.