

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MELDREN LATIBAN COTIC	Gender:	Female	Validity Between:	25/10/2024 and 08/02/2025
Card No:	E085-94F3-EB64-4568	DOB:	6/25/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-6781182-9	Service Date:	15-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971526519393		
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:	45544	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

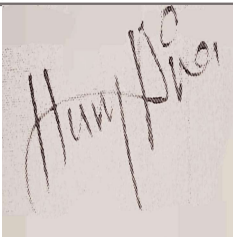
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint co pusy nodules in axilla in both sides 9th n jan. 2025 Imp 9th jan . 2025 oe pus is coming in both sides lymph nodes are also enlarged chest is clear no added sounds restless						DD	MM	YYYY
Past 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 : 136 T : 36.5 HR : 57 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	L02.411	Cutaneous abscess of right axilla					
Secondary	R50.9	Fever, unspecified					
Secondary	R52	Pain, unspecified					

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		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000		
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000		
86140	C-reactive protein;	Lab	15.0000		
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000		
Code	Generic	Duration	Instructions		
0005-107001-0051	(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 Day(s) others		
0195-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others		
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others		
☐ 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 : Humaira					
Tel / Fax (important):					
 Signature & Stamp 		 Patient's Signature(Parent if minor)			
Date :		Date : 15-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 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.