

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	RADHIYA ALI RAHIMI	Gender:	Female	Validity Between:	01/01/2024 and 31/12/2026
Card No:	833E-488B-7686-B6F3	DOB:	7/1/1947 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1947-8615941-1	Service Date:	19-Jan-2025	Radiology:	Covered
		Patent's Tel No:	971504641811		
Policy Holder:		Threshold Limit:			
Payer Name:	DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45438	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		
Complaint pc : known hypertensvive presented with severe pain on lefr side of neck, painful neck mivement and pain in knee joints bp is elevated						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 : 147 : 18	T : 36.8	HR : 87	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	M54.6	Pain in thoracic spine
Secondary	S13.8XXS	Sprain of joints and ligaments of oth parts of neck, sequela
Secondary	K29.00	Acute gastritis 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000

Code	Generic	Duration	Instructions
6616-533802-1751	(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) GASTRO-RESISTANT TABLETS	5	Take 1Gel 1 Time(s) per Day For 5 Day(s) morning empty stomach
0186-143702-0061	(CELECOXIB : 100 MG) CAPSULES	3	Take 1Gel 1 Time(s) per Day For 3 Day(s) others
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	3	Take 1Gel 1 Time(s) per Day For 3 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 1Gel 1 Time(s) per Day For 5 Day(s) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G GEL	5	Take 1Gel 3 Time(s) per Day For 5 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>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 : SANDIA		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 19-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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