## **eASOAP FORM**



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

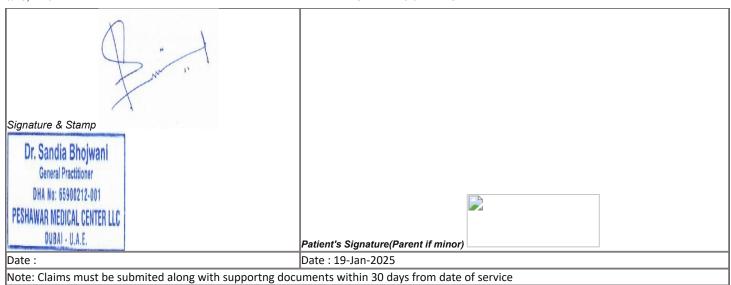
Patent Name: RADHIYA ALI RAHIMI Gender: **Female** Validity Between: 01/01/2024 and 31/12/2026 7/1/1947 12:00:00 **Coverage Information** Card No: 833E-488B-7686-B6F3 DOB: **Out Patient** AMfor: RN UAE (Al Ansari-AUH)-Pin #: Network: Identty Card: **MEDGULF** Natonal ID: 784-1947-8615941-1 Service Date: 19-Jan-2025 Radiology: Covered Patent's Tel No: 971504641811 Threshold Policy Holder: Limit: **DUBAI GOVERNMENT -**Normal Payer Name: Class: PROGRAM 1 (ENAYA) Out-Patent: Patent's File 45438 Co-Part: 20% Category: **Category B** Pharmacy: No: Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referred Service:

## SUBJECTIVE ASSESSMENT

Symptom(s)	as described by the p	Date of	Date of Symptoms/illness started							
Complaint		DD	MM	YYYY						
pc : known pain in kne	hypertensvive preser e joints									
bp is elevat	ted									
D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							Date of Symptoms/illness started			
Past Medical Surgical History?				○ Yes	○ No	DD	MM	YYYY		
Ol /C Cl- :	1	Date of	Date of Symptoms/illness started							
Obs/Gyn Clai	ims					DD	MM	YYYY		
Para	☐ Gravida:	□ АВ:	LMP:	Marital Status:	Marital Date:					
What date did	I the Patient first feel sa	ame / similar	Symptom(s	) : dd mm yyyy						
Is the Patient	under any type of Trea	tment? OY	es O No	if ves. indicate what	Assessment and since wh	nen:				

OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :					Vital Sigr ∷18	ns: B/P:1	47 T:30	5.8 HR : 87	RR			
Assessment/Diagnosis : Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM												
Туре	Code	Dia	Diagnosis									
Primary	M54.6	Pai	Pain in thoracic spine									
Secondary	ain of joint	in of joints and ligaments of oth parts of neck, sequela										
Secondary	Acı	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 re					elated injury/illness oc	cur:			
○ Yes ○ No			○ Yes ○ No									
Date of accident o	r beginning of illn	ess:										
MEDICAL PLAN Ite	mized Original Inv	oices and	Applicable	Prescriptions ,	/ Report	s / Results ı	must be enclosed	to consider claim				
CPT Code	Treatment							Туре	Price			
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular							Co.Pay	10.0000			
9	GP Consultatio	General Consultation	25.0000									
0125-122107- 1022	DEXAMETHASO INJECTION	ONE SODIL	Pharmacy	2.3400								
0005-149902- 1021	CLOFEN -(DICL	Pharmacy	6.5000									
Code	Generic					Duration	Instructions					
6616-533802- 1751	(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) GAST RESISTANT TABLETS					5	Take 1Gel 1 Time(s) per Day For 5 Day(s) morning empty stomach					
0186-143702- 0061	(CELECOXIB: 10					e(s) per Day For 3 Day(	per Day For 3 Day(s) others					
3819-373201- 0391	(TOLPERISONE	HCL : 150 ľ	MG) FILM C	COATED TABLET	ΓS	3	Take 1Gel 1 Time(s) per Day For 3 Day(s) others					
0027-142201- 0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER SOLUTION				5 Take 1Gel 1 Time(s) per Day For 5			e(s) per Day For 5 Day(s	s) others			
2093-596002- 0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / C				5 Take 1Gel 3 Time			e(s) per Day For 5 Day(s) others				
O Pharmacy: Estmate			ed Costs		OLab	Laboratory / Radiology:		Estmated Costs				
,			Taoru:		O Endoscopy:		01					
Is the following red	nuired	Surger			Other Procedures:							
Is the following required OPh			nysiotherapy:									
					lii yes b	lease specif	У					
ls In-patient Require					Indicat	e Provider		Estima	ate Cost			
I hereby certfy tha & that the medical medically indicated this case.	services shown o	n this form	n were	to release an	y inform ose of de	naton regar etermining i	ding my medical c nsurance benefts.	r, Employer or other Or onditon and history to Medical management	NEXtCARE			
Treating Physician N	Name : <b>SANDIA</b>											
Tel / Fax (important)	):											



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.