

eASOAP FORM

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

Patent Name:	MIRRIAM NTHAMBI MUTHIANI	Gender:	Female	Validity Between:	18/05/2024 and 17/05/2025
Card No:	2E0D-54EA-D63F-2AE8	DOB:	3/9/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-4198621-3	Service Date:	23-Jan-2025	Radiology:	Covered
		Patent's Tel No:	971568629523		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45624	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	DD MM YYYY
pc : right breast swelling, pain for 1 day	
breast feeding mom	

Complaint								
bp is elevated								
no other med conditions								
o/e redness upper lat quadrant of rt breast								
hot and tender on touch								
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 : 164 T : 38.7 HR : 108 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Secondary	R50.9	Fever, unspecified						
Primary	R21	Rash and other nonspecific skin eruption						
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
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
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
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000
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
0138-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
6616-533801-1751	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) morning empty stomach
2150-575201-1171	(CALCIUM : 400 MG (VITAMIN D3 : 200 IU (MAGNESIUM : 100 MG (ZINC : 4 MG TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
6603-159502-1171	(SERRATIOPEPTIDASE : 10 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
0186-143701-0061	(CELECOXIB : 200 MG) CAPSULES	3	Take 1 Unit(s), 1 Time(s) per Day For 3 Day(s)
3646-676703-0061	(FLUCLOXACILLIN SODIUM : 250 MG) CAPSULES	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		
 <i>Signature & Stamp</i> Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E		 <i>Patient's Signature(Parent if minor)</i>
Date :		Date : 23-Jan-2025
Note: Claims must be submitted along with supportng documents within 30 days from date of service		

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