

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	BLENDA DACULAN SAMONTE	Gender:	Female	Validity Between:	04/12/2024 and 03/12/2025
Card No:	E788-56F3-1A34-42C1	DOB:	11/6/1982 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1982-8400631-3	Service Date:	27-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0585512303		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45664	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

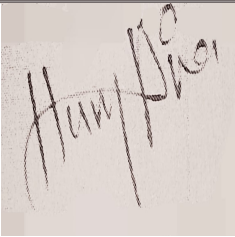
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started					
Complaint co dizzy back pain headache 2oth jan. 2025 oe elevated blood pressure no chest pain and no numbness of the hand nd arms chest is clear no added sounds restless						DD	MM	YYYY			
Past Medical Surgical History?						☐ Yes		☐ No			
						DD		MM		YYYY	
Obs/Gyn Claims						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 : 180 T : 36.4 HR : 72 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	I10	Essential (primary) hypertension					
Secondary	R51.9	Headache, unspecified					
Secondary	R34	Anuria and oliguria					
Secondary	E78.5	Hyperlipidemia, 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		
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000		
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000		
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000		
Code	Generic	Duration	Instructions		
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	3	Take 1 Tablets 2 Time(s) per Day For 3 Day(s) others		
6728-627102-1171	(AMLODIPINE (AS BESYLATE) : 10 MG) (VALSARTAN : 160 MG) TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)		
☐ 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 benefsts. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : Humaira					
Tel / Fax (important):					
 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		 Patient's Signature(Parent if minor)			
Date :		Date : 27-Jan-2025			
Note: Claims must be submitted along with supportng 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 effects 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.