eASOAP FORM



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

Patent Name:	ABDULLAH ALI	Gender:	Male	Validity Between:	21/02/2024 and 20/02/2025
Card No:	75EA-8385-50D5-BA2C	DOB:	2/8/2023 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-2023-1051980-0	Service Date:	05-Feb-2025	Radiology:	Covered
		Patent's Tel No:	0551687187		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41033	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred					
Service:					
SUBJECTIVE ASS	SESSMENT				
Symptom(s) as	described by the patent (C	hief Complaint):			Date of Symptoms/illness started

Symptom(s) as described by the patent (Chief Complaint):							Date of	Date of Symptoms/illness started		
Complaint						DD	MM	YYYY		
oe little blee	varound the nail bed d r no added sopunds	d 3rd feb. 20	025							
				ı					/III	
Past Medical Surgical History?					○ No	Date of	MM	s/illness started		
							DD	IVIIVI	TTTT	
							Date of	Symptom	s/illness started	
Obs/Gyn Clain				DD	ММ	YYYY				
Para	Gravida:	☐ AB:	LMP:	Marital Status	:	Marital Date:				
What date did t	he Patient first feel sa	me / similar s	Symptom(s)	: dd mm yyyy			<u>'</u>		*	
ls the Patient u	nder any type of Treat	tment? O Ye	es O No	if yes, indicate	e what Asses	sment and since w	vhen:			
OBJECTIVE / A	ASSESSMENT(To be	completed by	Physician)							
Clinical Findings :				Vital Signs : B/P : 00 T : : 24			T:37.3	: 37.3 HR : 110 RR		
Assessment/D	Diagnosis : O Ac DICATE DIAGNOSIS		Chronic OM	O Confirmed	d OSusp	ected				
Туре	Code	Diag	Diagnosis							
Primary	S91.225S	Lac	Lac w fb of left lesser toe(s) w damage to nail, sequela							
ACCIDENT/OC	CUPATIONAL Claim	Informaton	(complete	if claim is a re	sult of accid	ent or work relate	d illness/inju	ry)		
Accident or illness due to work? Injury due to roa accident?				to road	Describe ho	w the accident or	work related	injury/illne	ess occur:	
○ Yes ○ No	I		O Yes	No No						
Date of accide	ent or beginning of ill	Iness:			1					
	N Itemized Original I		Applicable	Prescriptions /	Reports / R	esults must be end	closed to cons	ider claim		

Code 0250-12580 Pharmacy Is the following Is In-patient Real thereby certifing the medically individual this case. Treating Physical Tel / Fax (imposite the control of the control o	whole face (803-0651 cy:	nd/or debrid or whole ex Generic (POVIDON	IE IODINE : 10%) OINTN	total body		Instructions		General Consultation Co.Pay	25.0000 30.0000			
Code 0250-12580 Pharmacy Is the following Is In-patient Ref I hereby certf & that the memodically inditaths case. Treating Physi Tel / Fax (imposite	whole face (803-0651 cy:	Generic (POVIDON	IE IODINE : 10%) OINTN	total body	Duration	Instructions		Co.Pay	30.0000			
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O250-12580 Pharmacy Is the following Is In-patient Reference of the series of the s	cy:	(POVIDON	Estmated Costs	MENT								
Is the following Is In-patient Real In-patient Individual	cy:		Estmated Costs	MENT	1			Duration Instructions				
Is the following the state of the following the state of	<u> </u>	l	_			Take 10intment 1 Time	(s) per	per Day For 1 Day(s) others				
Is In-patient Ro I hereby certf & that the me medically indi this case. Treating Physi Tel / Fax (impo	ing required		O 5	O Laboratory / Radiology:		Estmated Costs						
Is In-patient Ro I hereby certf & that the me medically indi this case. Treating Physi Tel / Fax (impo	ing required	ı	O Surgery:		O Endos	scopy:						
I hereby certy & that the me medically indi this case. Treating Physi Tel / Fax (impo			O Physiotherapy:		Other	ner Procedures:						
I hereby certy & that the me medically indi this case. Treating Physi Tel / Fax (impo					If yes please specify							
I hereby certy & that the me medically indi this case. Treating Physi Tel / Fax (impo	Required ? Le	ength of Stav	<u> </u>		Indicate F	Provider		Estimat	e Cost			
	medically indicated & necessary for the management of				any informat pose of dete	Healthcare Provider, Insu ton regarding my medica rmining insurance beneft and the patent.	l condi	iton and history to N	EXtCARE			
Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.				Patient's Si	gnature(Parei	nt if minor)						

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 final opinion will be given by the NEXtCARE claims doctors.

Note: Claims must be submited along with supporting documents within 30 days from date of service