

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	JESSICA JADE COX	Gender:	Female	Validity Between:	12/10/2024 and 11/10/2025
Card No:	2EED-07BB-C8FC-1051	DOB:	11/3/2001 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2001-5172597-3	Service Date:	26-Feb-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0529033886		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45271	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started						
Complaint PC : FLICKERING . PHOTSENSITIVITY , BLURRED VISIONS , SEVERE HEADACHE , USUALLY SRTARTS FROM NACK OF HEADE AND GOES AROUBD EYES ASSOCITAED WITH NAUSEA AND BLACK OUTS DISTURBIBG QUALITY OF LIFE AFRAID TO DRIVE WORK LIFE IS ISTURBED O/E : LOOK RESTLESS						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 : 117				T : 36.5		HR : 86		RR	
				: 18									
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected													
INDICATE DIAGNOSIS NOT SYMPTOM													
Type				Code				Diagnosis					
Primary				R52				Pain, unspecified					

Type	Code	Diagnosis
Secondary	R51.9	Headache, 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
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-149902-1021	CLOFEN	Pharmacy	6.5000

Code	Generic	Duration	Instructions
No Prescriptions History Found			

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
		If yes please specify	

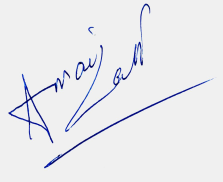
Is In-patient Required ? Length of Stay Indicate Provider Estimate Cost

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 benefets. Medical management is the sole responsibility of doctor and the patent.

Treating Physician Name : **DR Amaizah**

Tel / Fax (important):

Signature & Stamp  Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	<i>Patient's Signature(Parent if minor)</i> 
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Date : Date : 26-Feb-2025

Note: Claims must be submitted along with supporting 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.