

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AMANDA ELLA PAGADUAN ORGASAN	Gender:	Female	Validity Between:	30/06/2024 and 29/06/2025
Card No:	415F-66B9-5AF3-F606	DOB:	7/27/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-8305318-6	Service Date:	16-Mar-2025	Radiology:	Covered
		Patent's Tel No:	582583197		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42209	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred					
Service:					

SUBJECTIVE ASSESSMENT

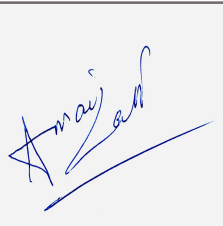
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint pc : pain and bleding from left cheek arounf lateral canthus of left eye hx of fall on ground o/e : laceration of approx 2*2cm around lat canthus of lft eye without foreign body						DD	MM	YYYY
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 : 136 T : 37.1 HR : 97 RR : 0			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	S01.01XD	Laceration without foreign body of scalp, subs encntr					
Secondary	R52	Pain, unspecified					
Secondary	E78.2	Mixed hyperlipidemia					
Secondary	I10	Essential (primary) hypertension					

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		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
0005-149902-1021	CLOFEN	Pharmacy	6.5000		
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		
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	Co.Pay	50.0000		
Code	Generic	Duration	Instructions		
0031-187502-0151	(BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM	3	topical only		
0397-116206-1171	(CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal		
0027-149903-0391	(DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal		
☐ 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 : DR Amaizah					
Tel / Fax (important):					
 Signature & Stamp 		 Patient's Signature(Parent if minor)			
Date :		Date : 16-Mar-2025			
Note: Claims must be submitted along with supporting documents within 30 days from date of service					

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