

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: INGRID MELONI	Gender: Female	Validity Between: 01/05/2024 and 30/04/2025
Card No: CFD5-06C4-8C59-86BE	DOB: 6/14/1988 12:00:00 AM	Coverage Information for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1988-9108587-4	Service Date: 18-Mar-2025	Radiology: Covered
	Patent's Tel No: 971506251509	
Policy Holder:	Threshold Limit:	
Payer Name: Jumeirah International LLC	Class: Normal	
	Out-Patient :	
Category: Category B	Patent's File No: 45467	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
patient got migrain attack since yeterday			YYYY
2 vomitting today and 3 yesterday			
severe bodyaches			
Past Medical Surgical History?		☐ Yes	☐ No
		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 : 144 T : 36.5 HR : 78 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	G43.909	Migraine, unsp, not intractable, without status migrainosus	
Secondary	R11.10	Vomiting, unspecified	
Secondary	R52	Pain, unspecified	

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

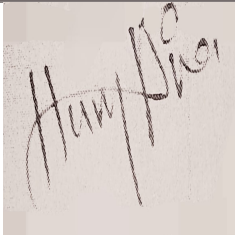
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	3.1000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-150403-1021	PREMOSAN	Pharmacy	0.9000

Code	Generic	Duration	Instructions
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G (POTASSIUM CHLORIDE : 0.3 G (SODIUM CITRATE : 0.58 G (GLUCOSE ANHYDROUS : 2.7 G POWDER FOR SOLUTION	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) before meal
0031-168201-0391	(DOMPERIDONE : 10 MG FILM COATED TABLETS	3	Take 1Tablets 3Time(s) perDay For 3 Day(s) before meal
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0135-223401-1171	(NAPROXEN : 500 MG TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

☐ 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>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
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 : 18-Mar-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.