

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: RENU NEPALI	Gender: Female	Validity Between: 25/07/2024 and 24/07/2025
Card No: 2252-FDA8-283B-2F81	DOB: 9/5/1988 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID: 784-1988-9284107-7	Service Date: 23-Mar-2025	Radiology: Covered
	Patent's Tel No: 0542028723	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 38445	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
pain in back after sleeping			YYYY
due to poor posture			
Past Medical Surgical History?	☐ Yes ☐ No	Date of Symptoms/illness started	
		DD	MM
			YYYY
Obs/Gyn Claims		Date of Symptoms/illness started	
☐ Para	☐ Gravida:	DD	MM
☐ AB:	LMP:		YYYY
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 : T : HR : RR :
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected	
INDICATE DIAGNOSIS NOT SYMPTOM	
Type	Code
Primary	M54.5
Secondary	R52
Secondary	I10
Diagnosis	
Low back pain	
Pain, unspecified	
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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000

Code	Generic	Duration	Instructions
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 1sachet 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	

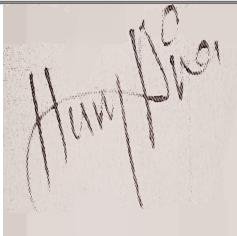
Is In-patient Required ? Length of Stay Indicate Provider Estimate Cost

I 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 : **Humaira**

Tel / Fax (important):

Signature & Stamp  	Patient's Signature(Parent if minor) 
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Date : Date : 23-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 efects 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.