

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MAHMOUD AHMED ABDALLAH HUSSAIN	Gender:	Male	Validity Between:	06/06/2024 and 05/06/2025
Card No:	4B43-40B2-47CF-0475	DOB:	10/31/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-9062029-1	Service Date:	28-May-2025	Radiology:	Covered
		Patent's Tel No:	585042746		
Policy Holder:		Threshold Limit:			
Payer Name:	Islamic Arab Insurance Co. (P.S.C.)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42457	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

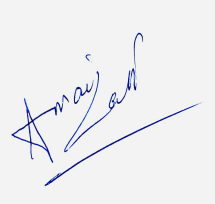
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started			
Complaint						DD	MM	YYYY	
pc : sevre flank pain on rt side , diziness , weak and lethargic , loss of appetite , low energy on and off for weeaks sever started on 27/05/25 o/e : look pale dehydrated tender rt flank and hypogastric									
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 : 120	T : 36.6	HR : 70	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	N21.8	Other lower urinary tract calculus				
Secondary	R52	Pain, unspecified				
Secondary	R50.9	Fever, unspecified				
Secondary	E86.0	Dehydration				
Secondary	R42	Dizziness and giddiness				
Secondary	N30.00	Acute cystitis without hematuria				
Secondary	R34	Anuria and oliguria				

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		
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000		
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000		
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000		
9	GP Consultation	General Consultation	25.0000		
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000		
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000		
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000		
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 		 Patient's Signature(Parent if minor)			
Date :		Date : 28-May-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.