eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the CITICARE MEDICAL CENTER LLC

net Compiainti.			Date of S	ymptoms/ill	ness started
nief Complaint):					
Consultaton :		Laboratory:	Covered	I	
Out-Patent : Patent's File No:	47147	Pharmacy:	Co-Part	: 20%	
Class:	Normal				
Threshold Limit:					
Patent's Tel No:	0567899213				
Service Date:	13-Jun-2025	Radiology:	Covered	I	
Identty Card:		Network:	RN UAE MEDGU	(Al Ansari-A LF	lUH)-
DOB:	7/13/1976 12:00:00 AM	Coverage Informaton for:	Out Pat	ient	
Gender:	Female	Validity Between:	11/04/20	25 and 30/08	3/2025
	Gender:	Gender: Female	Gender: Female Validity Between:	Gender: Female Validity Between: 11/04/20	Gender: Female Validity Between: 11/04/2025 and 30/08

patient came with the complain of blood in stool for the last one week she has painless bleeding per rectum no history on constipation o/e DRE no fissure and no blood is coming while examination Date of Symptoms/illness started Past Medical Surgical History? O Yes ○ No MM DD YYYY Date of Symptoms/illness started Obs/Gyn Claims 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? \bigcirc Yes \bigcirc No if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:110 T:36.6 HR: 84 RR 18 O Suspected Assessment/Diagnosis: ○ Acute O Chronic ○ Confirmed INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis K64.9 Unspecified hemorrhoids Primary K62.5 Hemorrhage of anus and rectum Secondary R52 Pain, unspecified Secondary D64.9 Anemia, unspecified Secondary ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

Describe how the accident or work related injury/illness occur:

Injury due to road

accident?

Accident or illness due to work?

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 General Consultation Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count Code Generic Duration Instructions 1732-531903- 0652 (ALLANTOIN: 0.5% W/W) (LIDOCAINE HCL: 0.5% W/W) OINTMENT 0071-158501- 0391 (HESPERIDIN: 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION): 450 0391 (HESPERIDIN: 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION): 450 Pharmacy: Estmated Costs Caber Pharmacy: Estmated Costs Caber Procedures: If yes please specify Indicate Provider Estimate Cost							1					
Type Price Price Price Price Price Price Price Price General Consultation Substitution Special Consultation Special Consulta				No								
Type Price												
General Consultation 25,0000 automated differential WBC count 25,0000 automated 25,0000 autom	MEDICAL PL	AN Iten	nized Original In	voices and	Applicable	Prescriptions /	Reports / Results	must be er	rclosed	to consider cl	laim	
Source Standard	III	Treatment								Туре	Туре	
automated differential WBC count Code Generic Take 10 instructions Take 11 instructions Take 10 instructions Take 11 instructions Take 10 instructions Take 11 instructi	9	GP Consultation									ion	25.0000
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Day(s) others Day(s) others	II (ALLANTOIN : 0.5% W/W) (TIDOCAINE					HCL : 0.5% W						
Surgery: Other Procedures: If yes please specify Sin-patient Required? Length of Stay I hereby certfy that all informaton mentoned are correct At that the medical services shown on this form were medically indicated & necessary for the management of his case. Treating Physician Name: AISHA Tel / Fax (important): Signature & Stamp Ot. Aisha Uner Physical Geneta Patitione Oth-Mistay Uner Display-U.L.E. Patient's Signature(Parent if minor) Date: 13-Jun-2025						VONOIDIC FRA						
Indicate Provider Se In-patient Required ? Length of Stay Indicate Provider Indicat	OPharma	OPharmacy: Estmated Costs					Claboratory / Radiology: Es			Estmated Costs		
If yes please specify Is In-patient Required? Length of Stay I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: AISHA Tel / Fax (important): Signature & Stamp Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Dt. AISHa Uner Physician Sental Practions Dt. AISHa Uner Physician Name: AISHA Dt. AIS		○ Surgery:					○ Endoscopy:					
Indicate Provider I hereby certfy that all informaton mentoned are correct I hereby certfy that all informaton mentoned are correct I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Or. AISTA UME! Physician General Practitione OHA 4013143-002 CITICARE MEDICAL CENTER DUBAL-U.A.E. Patient's Signature(Parent if minor) Date : 13-Jun-2025				Other Procedures:								
I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Alsha Uner Physician Geneal Praditioner DHA 4031439-002 CITICARE MEDICAL CENTER DUBNI-VIAE DUBNI-VIAE Date : Date: 13-Jun-2025												
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to release any informaton regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp					are correct	I hereby auth		are Providei	r Insure	r Employer o		
Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Aisha Umer Physician- General Practitioner OHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI- U.A.E Patient's Signature(Parent if minor) Date : 13-Jun-2025	& that the n	, ,,				to release any informaton regarding my medical conditon and history to NEXtCARE						
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Signature & Stamp Dr. Alsha Umer Physician- General Practitioner DHA- 40731439-002 CITICARE MEDICAL CENTER DUBAI- U.A.E Patient's Signature(Parent if minor) Date: Date:	-		ame . Alona									
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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 final opinion will be given by the NEXtCARE claims doctors.