# eASOAP FORM

**ADMINISTRATIVE** The member is allowed for **Out Patient** at the **CITICARE MEDICAL CE**

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **NAYAB GUL FAZAL UR REHMAN** | Gender: | **Female** | Validity Between: | **20/05/2025 and** |
| Card No: | **AAE1-9865-CF74-C3AE** | DOB: | **2/11/1996 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ans MEDGULF** |
| Natonal ID: | **784-1996-6042514-3** | Service Date: | **24-Aug-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0507342796** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **47472** | 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 Sympton** | |
|---|---|---|
| **Complaint** | DD | MM |
| PC : BOTH BIG TOE NAIL PAIN<br>PT CAME WITH THE COMPLAIN OF BOTH BIG TOE PAIN DUE TO FUNGUS STARTING ONE MONTH BACK<br>O/E NAIL IS HALF GREY AND PAINFUL<br>ALLERGIES : NONE<br>PMH : NONE | | |

| **Past Medical Surgical History?** | ○ Yes | ○ No | **Date of Symptor** | |
|---|---|---|---|---|
| | | | DD | MM |
| | | | | |

| Obs/Gyn Claims | | | | | | **Date of Symptor** | |
|---|---|---|---|---|---|---|---|
| | | | | | | DD | MM |
| ☐ 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 : T : HR : |
|---|---|
| | |

**Assessment/Diagnosis :** ○ Acute ○ Chronic ○ Confirmed ○ Suspected

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | S90.211A | Contusion of right great toe w damage to nail, init encntr |
| Secondary | S91.241A | Pnctr w fb of right great toe w damage to nail, init |

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

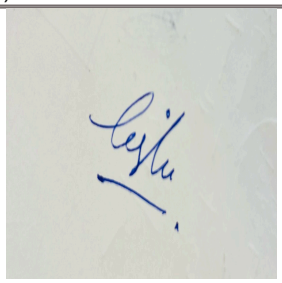
| Accident or illness due to work? | Injury due to road accident? | Describe how the accident or work related injury/illn |
|---|---|---|
| ○ Yes ○ No | ○ Yes ○ No | |
| Date of accident or beginning of illness: | | |

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

| CPT Code | Treatment | Type |
|---|---|---|
| 9 | GP Consultation | General Consultation |
| 11730 | Avulsion of nail plate, partial or complete, simple; single | Co.Pay |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| No Prescriptions History Found | | | |

| ○ Pharmacy: | Estmated Costs | ○ Laboratory / Radiology: | Estmated Costs |
|---|---|---|---|
| Is the following required | ○ Surgery: | ○ Endoscopy: | |
| | ○ Physiotherapy: | ○ Other Procedures: | |
| | | If yes please specify | |

| Is In-patient Required ? Length of Stay | Indicate Provider |
|---|---|
| *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.* | *I hereby authorize any Healthcare Provider, Insurer, Employer or ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefts. Medical manage responsibility of doctor and the patent.* |
| Treating Physician Name : **AISHA** | |
| Tel / Fax (important): | |
| *Signature & Stamp*  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E | ***Patient's Signature(Parent if minor)*** |
| Date : | Date : 24-Aug-2025 |

Note: Claims must be submited along with supportng 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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX doctors.