

eASOAP FORM


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

Patent Name:	ZAHRA HOSSEIN SHAFIE	Gender:	Female	Validity Between:	17/05/2024 and 16/05/2025
Card No:	C6A4-D193-6A02-5C4B	DOB:	5/18/1986 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1986-4456529-7	Service Date:	20-Aug-2024	Radiology:	Covered
		Patent's Tel No:	0543419617		
Policy Holder:		Threshold Limit:			
Payer Name:	ARABIA INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43876	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: Back pain, posterior neck pain, pain in the left shoulder radiating down the ipsilateral upper limb since the past 3days. Has recently started gyming but there is no history of trauma. She is not a known hypertensive and not diabetic. Has no previous history of similar condition. Exam: Restriction in both active and passive movements of the shoulder joint.								
Past Medical Surgical History? ☐ Yes ☐ No						Date of Symptoms/illness started		
						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 : 126	T : 37.6	HR : 68	RR : 20
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	M25.511	Pain in right shoulder
Secondary	G24.3	Spasmodic torticollis
Secondary	R50.9	Fever, unspecified
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
Secondary	K29.50	Unspecified chronic gastritis without bleeding

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:		

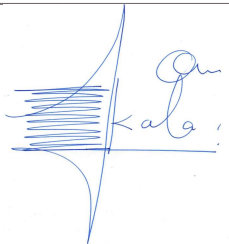
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
82310	Calcium; total	Lab	10.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000

Code	Generic	Duration	Instructions
2320-149914-0722	(DICLOFENAC SODIUM : 140 MG) PATCHES	5	Take 1Units 4 Time(s) per Day For 5 Day(s) others
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0188-232402-0391	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0027-149903-0391	(DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal

☐ 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 mentioned 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 Organization 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 : Enomen Goodluck		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 20-Aug-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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