

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MARWAN ABDELAZIZ	Gender:	Male	Validity Between:	16/08/2024 and 15/08/2025
Card No:	75FF-E512-4373-E098	DOB:	9/29/1998 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1998-1127338-4	Service Date:	24-Nov-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0527126137		
		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43879	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

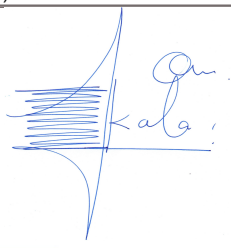
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: Pain in throat, cough, generalized body pains and fever.								
Duration: 1 day								
Has LADA, diagnosed 2 years ago and on 12hrly daily dose of galvusmet.								
He is not hypertensive..								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:	DD	MM	YYYY
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 : 100 T : 36.2 HR : 76 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	K29.00	Acute gastritis without bleeding					

ACCIDENT/OCCUPATIONAL Claim Information (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
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug			Co.Pay	10.0000
9	GP Consultation			General Consultation	25.0000
82947	Glucose; quantitative, blood (except reagent strip)			Lab	12.0000
83036	Hemoglobin; glycosylated (A1C)			Lab	30.0000
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
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
Code	Generic		Duration	Instructions	
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION		3	Take 1Powder 3 Time(s) per Day For 3 Day(s) after meal	
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS		10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal	
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS		10	Take 1Tablets 1 Time(s) per Day For 10 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 benefsts. Medical management is the sole responsibility of doctor and the patent.		
Treating Physician Name : Enomen Goodluck					
Tel / Fax (important):					
 Signature & Stamp			 Patient's Signature(Parent if minor)		
					
Date :			Date : 24-Nov-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service					

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