

eASOAP FORM


ADMINISTRATIVE

 The member is allowed for **Out Patient**

 at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	KHORSHED ABUL KASHAM	Gender:	Male	Validity Between:	01/05/2024 and 30/04/2025
Card No:	B54F-CD95-5E75-D29C	DOB:	2/3/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-8070592-5	Service Date:	26-Nov-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0543668997		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43782	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

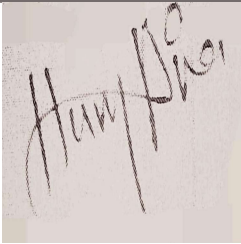
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint co thirsty dehydration increased frequency of urine 1 month nov . 2024 oe chest is clear no added sounds restless						DD	MM	YYYY
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ 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 : 110 T : 36 HR : 86 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	E86.0	Dehydration			
Secondary	R73.9	Hyperglycemia, unspecified			

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	
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000	
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 : Humaira				
Tel / Fax (important):				
 Signature & Stamp 		 Patient's Signature(Parent if minor)		
Date :		Date : 26-Nov-2024		
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 efects 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.