eASOAP FORM

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

Patent Name:	**Ali Mohammad Beloshi**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**33C7-A345-3B99-FD89**	DOB:	**12/18/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1982-7581691-0**	Service Date:	**19-Jul-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0506400553**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43609**	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: fever 2 days flu and cold cough 2 days sorethroat headache			

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 : 109 T : 37.1 HR : 91 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	R52	Pain, unspecified
Secondary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J00	Acute nasopharyngitis [common cold]

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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
2040-106618-1001	PARACETAMOL S.A.L.F (PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
0005-107704-0802	TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

Code	Generic	Duration	Instructions
7512-014201-1161	(ADHATODA VASICA : 112.5 MG/10ML) (TULSI (OCIMUM SANCTUM) : 90MG/10ML) (SOLANUM XANTHOCARPUM : 90MG/10ML) (TERMINALIA BELLIRICA EXTRACT : 52.5 MG/10ML) (HEDYCHIUM SPICATUM : 37.5 MG/10ML) (GLYCYRRHIZA GLABRA EXTRACT : 22.5 MG/10ML) (PIPER LONGUM : 22.5 MG/10ML) SYRUP	7	Take 2.5 ml Syrup 2 Time(s) per Day For 7 Day(s) after meal
0195-123701-0391	CETIRIZINE HCL	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening before sleep
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal

○ 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	Estimate Cost
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 other Organizaton to release any informaton regarding my medical conditon 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 : **Enomen Goodluck**		
Tel / Fax (important):		
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 19-Jul-2024	

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 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.