

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Padma Deepati Deepati Narasimha Murth	Gender:	Female	Validity Between:	09/02/2024 and 08/02/2025
Card No:	3EAF-DDB4-2263-91A7	DOB:	4/10/1977 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1977-8104326-6	Service Date:	02-Aug-2024	Radiology:	Covered
		Patent's Tel No:	0588051372		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43740	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 PC: FEVER 2 DAYS BODY PAIN COLD SORETHROAT COUGH						DD	MM	YYYY	
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 : 138	T : 37.3	HR : 122	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J00	Acute nasopharyngitis [common cold]
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	M54.5	Low back pain

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:		

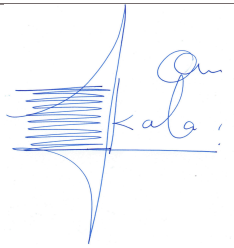
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
2040-106618-1001	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-107704-0801	Triaxone (Ceftriaxone [1 G]) Powder For Injection (1 + 3.5ml, Vial + Solvent Ampoule)	Pharmacy	58.5000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
2593-994501-1161	(IVY LEAF EXTRACT : 0.7 G/100ML) SYRUP	5	Take 3.5 ML Syrup 2 Time(s) per Day For 5 Day(s) after meal
0005-938301-3381	(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
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
0195-123701-0391	CETIRIZINE HCL	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal AT NIGHT BEFORE SLEEP

☐ 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 mentoned 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 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.</i>		
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 : 02-Aug-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 creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.