

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	SAMER ABDULAZIZ KANNOUT	Gender:	Male	Validity Between:	16/11/2023 and 15/11/2024
Card No:	2C35-F5B0-92F8-4535	DOB:	2/20/1971 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1971-9284364-3	Service Date:	08-Aug-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971505344144		
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:	39683	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: SORETHROAT								
FEVER								
COUGH								
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 : 37.2 HR : 86 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	M62.81	Muscle weakness (generalized)					

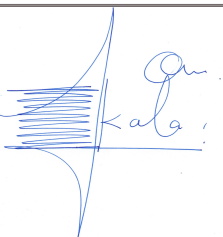
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000

Code	Generic	Duration	Instructions
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
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	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	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	CETIRIZINE HCL	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening 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 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. Treating Physician Name : Enomen Goodluck Tel / Fax (important):		
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 benefuts. Medical management is the sole responsibility of doctor and the patent.		
Signature & Stamp  Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. 		
Date :	Date : 08-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.