

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MOHASIN SK Year ALI SK	Gender:	Male	Validity Between:	01/05/2024 and 30/04/2025
Card No:	FB60-1C2B-DD79-FE3E	DOB:	5/21/1996 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1996-3760696-5	Service Date:	08-Aug-2024	Radiology:	Covered
		Patent's Tel No:	0555376966		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43796	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
Nasal congestion, fever, headache and myalgia.			
Duration: 2days			
BP at presentation is 202/140mhg (hypertensive urgency).			
Claims he used to take antihypertensive but stopped many months ago.			

Complaint								
Refer to internal medicine on the suspicion of secondary hypertension based on his age.								
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 : 202	T : 37.7	HR : 109	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J06.9	Acute upper respiratory infection, unspecified				
Secondary	J30.9	Allergic rhinitis, unspecified				
Secondary	R50.9	Fever, unspecified				
Secondary	I16.0	Hypertensive urgency				
Secondary	I15.9	Secondary hypertension, 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

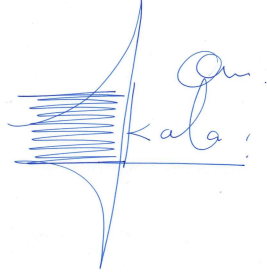
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000

CPT Code	Treatment	Type	Price
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

Code	Generic	Duration	Instructions
0005-116801-1161	(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	7	Take 10ML 2 Time(s) per Day For 7 Day(s) after meal
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	4	Take 2Tablets 2 Time(s) per Day For 4 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) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal
1394-618004-0391	(OLMESARTAN MEDOXOMIL : 40 MG) (AMLODIPINE (AS BESYLATE) : 10 MG) FILM COATED TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening

☐ 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</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</i>		

<i>medically indicated & necessary for the management of this case.</i>	<i>for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.</i>
Treating Physician Name : Enomen Goodluck	
Tel / Fax (important):	
 <i>Signature & Stamp</i> Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 08-Aug-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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