

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: JENITHA PALIN	Gender: Female	Validity Between: 25/01/2024 and 24/01/2025
Card No: 6F14-AAF8-ACF8-4D17	DOB: 9/28/1997 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1997-2802421-9	Service Date: 11-Aug-2024	Radiology: Covered
	Patent's Tel No: 0588170470	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 42924	Pharmacy: Co-Part: 20%
Gatekeeper: No	Consultaton :	Laboratory: Covered
Referral No:		
Referred		
Service:		

SUBJECTIVE ASSESSMENT

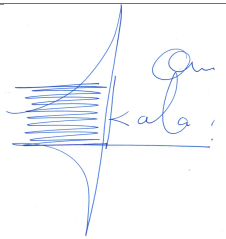
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: Difficulty breathing, especially at night, cough and wheezing. Also has shivering, pain in both eyes, with redness and wateriness. Also has low back pain and weakness. does not smoke tobacco. Currently on treatment for polio arthritis. names of current medicines unknown. Chest examination: No abnormality detected.						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 : 124 T : 37 HR : 89 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J22	Unspecified acute lower respiratory infection					
Secondary	R06.00	Dyspnea, unspecified					
Secondary	R06.2	Wheezing					
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		
9	GP Consultation	General Consultation	25.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
0005-149902-1021	CLOFEN	Pharmacy	6.5000		
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400		
86140	C-reactive protein;	Lab	15.0000		
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000		
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300		
0188-135906-2441	PULMICORT	Pharmacy	10.4800		
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000		
Code	Generic	Duration	Instructions		
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) after meal		
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal		
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal		
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others		
☐ 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 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 benefets. 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 : 11-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.