

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	JAD SAMER KANNOUT	Gender:	Male	Validity Between:	16/11/2023 and 15/11/2024
Card No:	B62D-4D67-51F1-9840	DOB:	12/20/2016 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2016-7107943-8	Service Date:	03-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0507740340		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	37828	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

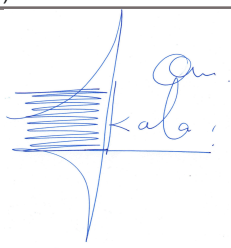
Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint					DD	MM	YYYY
PC: Fever 2 days ago, did not persist till presentation. Rashes on the skin, including the sole of the feet, palm of hands and roof of mouth. There is no cough and fever has abated. There is no headache, no photophobia and no phonophobia but has pain in throat especially on swallowing.							
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 : 0	T : 37.5	HR : 0	RR : 26
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	A88.0	Enteroviral exanthematous fever [Boston exanthem]			
Secondary	R50.9	Fever, 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
Code	Generic	Duration	Instructions
0005-662702-0991	(PREDNISOLONE (SODIUM PHOSPHATE) : 15MG/5ML) SOLUTION	5	Take 5ML 1 Time(s) per Day For 5 Day(s) after meal
4874-125821-3801	(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	7	Take 1Spray 3 Time(s) per Day For 7 Day(s) after meal
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 7.5ML 2 Time(s) per Day For 5 Day(s) after meal
5363-949001-1161	(CHLORPHENIRAMINE MALEATE : 0.75 MG/5 ML) (PARACETAMOL : 120 MG/5ML) (PSEUDOEPHEDRINE HCL : 15 MG/5ML) SYRUP	7	Take 6ML 2 Time(s) per Day For 7 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>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 		 Patient's Signature(Parent if minor)
Date :		Date : 03-Sep-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 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 effects 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.