# 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** |
| | | Patent's Tel No: | **0507740340** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **37828** | 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 |
| PC: Fever 2 days ago, did not persist till presentation.<br>Rashes on the skin, including the sole of the feet, palm of hands and roof of mouth.<br>There is no cough and fever has abated.<br>There is no headache, no photophobia and no phonophobia but has pain in throat especially on swallowing. | | | |

| **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 : 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: | Estmated Costs | ○ Laboratory / Radiology: | Estmated 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 benefts. Medical management is the sole responsibility of doctor and the patent.* | |
| Treating Physician Name : **Enomen Goodluck** | | |
| Tel / Fax (important): | | |
| *Signature & Stamp*<br>Dr. Enomen Goodluck Ekata<br>General Practitioner<br>DHA No: 28040827-001<br>CITICARE MEDICAL CENTER LLC<br>DUBAI - U.A.E. | ***Patient's Signature(Parent if minor)*** | |
| Date : | Date : 03-Sep-2024 | |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | | |

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