eASOAP FORM

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

Patent Name:	**SHIRLEY CARPIO MEDALLA**	Gender:	**Female**	Validity Between:	**31/01/2024 and 30/01/2025**
Card No:	**FCF1-4864-6D60-B55F**	DOB:	**1/11/1979 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1979-4149709-7**	Service Date:	**04-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0529722714**		
Policy Holder:		Threshold Limit:			
Payer Name:	**UNITED INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44017**	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 sorethroat cough anal fissue previously known and constipated low back ache asthma mild abdominal; migraine			

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 : 106 T : 37.1 HR : 94 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	G43.D0	Abdominal migraine, not intractable

Type	Code	Diagnosis
Secondary	K60.2	Anal fissure, unspecified
Secondary	M54.5	Low back pain
Secondary	K59.00	Constipation, unspecified
Secondary	J20.9	Acute bronchitis, 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0005-107704-0802	TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

Code	Generic	Duration	Instructions
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 1 Time(s) per Day For 30 Day(s) others
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	10	Take 1Syrup 1 Time(s) per Day For 10 Day(s) others
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	15	Take 1sachet 2 Time(s) per Day For 15 Day(s) others
0006-199804-1971	(SUMATRIPTAN : 10 MG) LIQUID FOR SPRAY (NASAL)	30	Take 1Spray 2 Time(s) per Day For 30 Day(s) others
0086-225101-2091	(POTASSIUM CHLORIDE : 46.6 MG) (POLYETHYLENE GLYCOL : 13.125 G) (SODIUM BICARBONATE : 178.5 MG) (SODIUM CHLORIDE : 350.7 MG) ORAL POWDER	30	Take 1sachet 3 Time(s) per Day For 30 Day(s) others
Q57-6460-06592-01	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	30	Take 1Ointment 2 Time(s) per Day For 30 Day(s) others
6495-751902-3851	(N-ACETYL CYSTEINE : 6 %/30ML) (SODIUM CHLORIDE : 3 %/30ML) NASAL SPRAY	30	Take 1Spray 2 Time(s) per Day For 30 Day(s) others
2048-565706-1391	(FLUTICASONE PROPIONATE : 250 MCG/DOSE) (FORMOTEROL FUMARATE : 5MCG/DOSE) AEROSOL INHALER	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0110-116501-1451	(AMPICILLIN : 250 MG) CAPSULES (HARD GELATIN)	14	Take 1Tablets 1 Time(s) per Day For 14 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 : **AHSAN HUSSAIN**	
Tel / Fax (important):	

Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 04-Sep-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	