

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Robin Weber	Gender:	Male	Validity Between:	01/10/2023 and 30/09/2024
Card No:	15BC-AE82-1A87-6BF3	DOB:	8/8/1990 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1990-5917393-2	Service Date:	05-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0565542659		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44034	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
KNOWN ASTHMATIC								
FEVER								
FLU COLD								
ANAL FISSURE PREVIOUSLY KNOWN								
LOW BACK ACHE								
CONSTIPATION 5 DAYS								
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 : 150 T : 36.9 HR : 86 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J00	Acute nasopharyngitis [common cold]					
Secondary	J45.20	Mild intermittent asthma, uncomplicated					
Secondary	K60.2	Anal fissure, unspecified					

Type	Code	Diagnosis
Secondary	K59.00	Constipation, 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
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

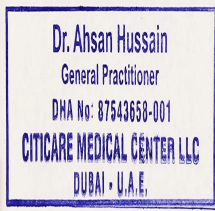
Code	Generic	Duration	Instructions
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Solution 1 Time(s) per Day For 30 Day(s) others
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	14	Take 1Syrup 2 Time(s) per Day For 14 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	15	Take 1sachet 2 Time(s) per Day For 15 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 1 Time(s) per Day For 30 Day(s) others
6495-751902-3851	(N-ACETYL CYSTEINE : 6 %/30ML) (SODIUM CHLORIDE : 3 %/30ML) NASAL SPRAY	15	Take 1Spray 2 Time(s) per Day For 15 Day(s) others
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	14	Take 1Tablets 1Time(s) perDay For 14 Day(s) after meal

☐ 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 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> <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 : AHSAN HUSSAIN		
Tel / Fax (important):		



Signature & Stamp



Patient's Signature(Parent if minor)



Date :

Date : 05-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 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.