eASOAP FORM

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

Patent Name:	**SABITRI SAPKOTA SAPKOTA**	Gender:	**Female**	Validity Between:	**06/12/2023 and 05/12/2024**
Card No:	**9D09-A8C6-51D8-1524**	DOB:	**8/4/1989 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1989-7293970-0**	Service Date:	**07-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0561039734**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43268**	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: LYMPH NODE SWELLING SUBMANDIBULAR					
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 : 37.8	HR : 85	RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	L04.0	Acute lymphadenitis of face, head and neck
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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000
2040-106618-1001	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
9	GP Consultation	General Consultation	25.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-107704-0802	TRIAXONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

Code	Generic	Duration	Instructions
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
2626-293402-0391	(LINEZOLID : 600 MG) FILM COATED TABLETS	14	Take 1Tablets 1Time(s) perDay For 14 Day(s) after meal

○ 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 : 07-Sep-2024
Note: Claims must be submited along with supportng 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 efects 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.