

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Faria Sabir Sabir Hussain	Gender:	Female	Validity Between:	20/07/2024 and 19/07/2025
Card No:	DF13-81C6-2A6C-C391	DOB:	7/10/1996 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1996-6604380-9	Service Date:	08-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0524547324		
Policy Holder:		Threshold Limit:			
Payer Name:	MetLife	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43587	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 PC: FEVER COUGH KNOWN ASTHMATIC FLU BACK ACHE CONSTIPATION EPIGASTRIC PAIN						DD	MM	YYYY
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 : 100	T : 38.2	HR : 112	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J06.9	Acute upper respiratory infection, unspecified				
Secondary	J20.9	Acute bronchitis, unspecified				
Secondary	J45.20	Mild intermittent asthma, uncomplicated				
Secondary	K59.00	Constipation, unspecified				
Secondary	J00	Acute nasopharyngitis [common cold]				

Type	Code	Diagnosis
Secondary	M54.5	Low back pain

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
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
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
2040-106618-1001	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	10.7500
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

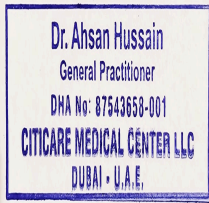
Code	Generic	Duration	Instructions
7512-014201-1161	(ADHATODA VASICA : 112.5 MG/10ML) (TULSI (OCIMUM SANCTUM) : 90MG/10ML) (SOLANUM XANTHOCARPUM : 90MG/10ML) (TERMINALIA BELLIRICA EXTRACT : 52.5 MG/10ML) (HEDYCHIUM SPICATUM : 37.5 MG/10ML) (GLYCYRRHIZA GLABRA EXTRACT : 22.5 MG/10ML) (PIPER LONGUM : 22.5 MG/10ML) SYRUP	7	Take 1Syrup 2 Time(s) per Day For 7 Day(s) others
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	14	Take 1Tablets 1Time(s) perDay For 14 Day(s) before meal
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	14	Take 1Solution 2 Time(s) per Day For 14 Day(s) others
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	7	Take 1sachet 3 Time(s) per Day For 7 Day(s) after meal
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	15	Take 1sachet 1 Time(s) per Day For 15 Day(s) after meal
0005-938301-3381	(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	10	Take 1Tablets 3 Time(s) per Day For 10 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 benefsts. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : AHSAN HUSSAIN		
Tel / Fax (important):		



Signature & Stamp



Patient's Signature(Parent if minor)



Date :

Date : 08-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.