eASOAP FORM

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

Patent Name:	**MYSHA SAMIR DIGE SAMIR DIGE**	Gender:	**Female**	Validity Between:	**12/09/2023 and**
Card No:	**53C8-4049-2FDB-F94F**	DOB:	**10/30/2022 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-2022-6769840-9**	Service Date:	**11-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0525430515**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44125**	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 Symptom**	
Complaint	DD	MM
PC: Intermittent fever since the past 2days. Fever said to be high grade and temperature at presentation is 38.1degree. Has cough and runny nose as well. Also irritable cries and fussiness. No change in bowel. Exam: inflamed and hypertrophied tonsils		

Past Medical Surgical History?	○ Yes	○ No	**Date of Symptom** DD	MM

Obs/Gyn Claims						**Date of Symptom** DD	MM
☐ 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 : 38.1 HR : RR : 20

Assessment/Diagnosis : ◯ **Acute** ◯ **Chronic** ◯ **Confirmed** ◯ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough

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/illne
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

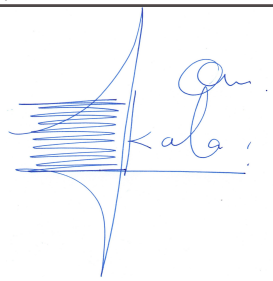
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0

Code	Generic	Duration	Instruc
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	10	Take 5M Day For others
0005-662702-0991	(PREDNISOLONE (SODIUM PHOSPHATE) : 15MG/5ML) SOLUTION	7	Take 3M Day For evening
0796-605201-0221	(VITAMIN A PALMITATE : 1500 IU/ML) (VITAMIN D3 : 400 IU/ML) (VITAMIN E (AS D-ALPHA TOCOPHERYL ACETATE) : 5 IU/ML) (ASCORBIC ACID (VITAMIN C) : 30 MG/ML) (NIACINAMIDE : 4 MG/ML) (THIAMINE (VITAMIN B1) : 0.5 MG/ML) (RIBOFLAVINE (VITAMIN B2) : 0.6MG/ML) DROPS	15	Take 5M perDay evening
0325-142903-0851	(CEFIXIME : 100 MG/5ML) POWDER FOR SUSPENSION	7	Take 7.5 per Day after m
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 5M Day For meal
0027-149905-2231	(DICLOFENAC SODIUM : 12.5 MG) RECTAL SUPPOSITORIES	5	Take 1S 1Time(Day(s)

◯ 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
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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managemer responsibility of doctor and the patent.*
Treating Physician Name : **Enomen Goodluck**	
Tel / Fax (important):	
 *Signature & Stamp* 	***Patient's Signature(Parent if minor)***
Date :	Date : 11-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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.