

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Salah Khan Shayaan Khan Shahzad	Gender:	Male	Validity Between:	11/07/2024 and 10/07/2025
Card No:	DBE6-6D05-3FF8-5DD8	DOB:	6/27/2021 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2021-5915878-5	Service Date:	14-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0564800621		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44167	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: High grade fever since yesterday. Said to also have pain in throat, cough, runny nose and nasal congestion. Also has loose motion but no blood nor mucus in stool. Temperature at presentation is 40.7 degree ENT: shows markedly inflamed and hypertrophied tonsils.						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 : 0	T : 40.1	HR : 130	RR : 28
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				

Type	Code	Diagnosis
Secondary	R09.81	Nasal congestion

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:		

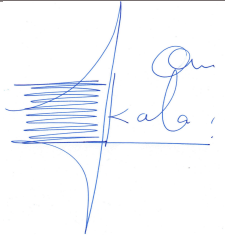
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
0027-128801-1971	(XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL)	5	Take 2Drops 3 Time(s) per Day For 5 Day(s) others
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others
0005-662702-0991	(PREDNISOLONE (SODIUM PHOSPHATE) : 15MG/5ML) SOLUTION	7	Take 3ML 1 Time(s) per Day For 7 Day(s) after meal
1516-106606-1161	(PARACETAMOL : 250 MG/5ML) SYRUP	5	Take 5ML 3 Time(s) per Day For 5 Day(s) after meal
0325-142903-0851	(CEFEXIME : 100 MG/5ML) POWDER FOR SUSPENSION	7	Take 10ML 1 Time(s) per Day For 7 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 benefits. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		



Signature & Stamp

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient's Signature(Parent if minor)



Date :

Date : 14-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.