

eASOAP FORM


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

Patent Name:	PRIYANKA PRAKASH PRAKASH	Gender:	Female	Validity Between:	09/06/2024 and 08/06/2025
Card No:	2AB3-46AE-4728-8199	DOB:	12/21/1994 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1994-6944740-5	Service Date:	16-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0525703735		
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:	40067	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
co fever on and off itching in the throat cold cough								
oe								
enlarge tonsillls inflamed throat								
chest is congested o added sounds								
restless taking tablet levothyroxine 75mcg								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	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 : 92	T : 37.2	HR : 100	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J03.90	Acute tonsillitis, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R05	Cough
Secondary	R10.13	Epigastric 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:		

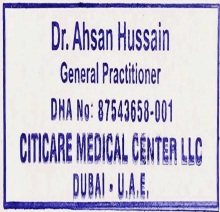
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

Code	Generic	Duration	Instructions
0281-367801-0431	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	14	Take 1Gel 2 Time(s) per Day For 14 Day(s) others
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 1Syrup 2 Time(s) per Day For 7 Day(s) others
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
0005-938301-3381	(CAFFEINE ANHYDROUS : 25 MG) (PARACETAMOL : 500 MG) (PHENYLEPHRINE HCL : 5 MG) CAPLET-TABLET	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0195-123701-0391	CETIRIZINE HCL	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others BEFORE SLEEP

☐ 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 hereby certify 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):	
 <i>Signature & Stamp</i> 	  <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 16-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.