

eASOAP FORM

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

Patent Name:	Salah Khan Shayaan Khan Shahzad	Gender:	Male	Validity Between:	11/07/2024 and 1
Card No:	DBE6-6D05-3FF8-5DD8	DOB:	6/27/2021 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans: MEDGULF
Natonal ID:	784-2021-5915878-5	Service Date:	16-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0564800621		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44167	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
No Complaints Found for Selected Appointment							
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 : 00 T : 38.7 HR : RR : 24		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J03.90	Acute tonsillitis, unspecified			

Type	Code	Diagnosis
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
9.01	Follow-up consultation	General Consultation

Code	Generic	Duration	Instructions
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	7	Take 5ML 1 Time(s) per Day For 7 Day
0005-106604-1111	(PARACETAMOL : 120 MG/5ML) SUSPENSION	5	Take 10ML 3 Time(s) per Day For 5 D
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 7.5ML 3 Time(s) per Day For 5 D
0027-149906-2231	(DICLOFENAC SODIUM : 25 MG) RECTAL SUPPOSITORIES	5	Take 1Suppository 1 Time(s) per Day after meal

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
	If yes please specify		

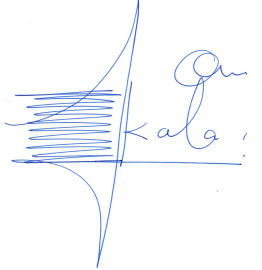
Is In-patient Required ? Length of Stay Indicate Provider

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 benefets. Medical managemer responsibility of doctor and the patent.

Treating Physician Name : **Enomen Goodluck**

Tel / Fax (important):


Signature & Stamp


Patient's Signature(Parent if minor)

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

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. We will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NEtcare has no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the Netcare doctors.