

eASOAP FORM

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

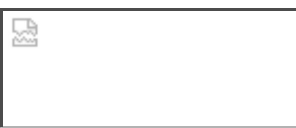
Patent Name:	AMIRA HAMZA	Gender:	Female	Validity Between:	12/07/2024 and 12/07/2025
Card No:	E882-29CD-57A6-CD42	DOB:	7/14/1988 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ansar MEDGULF)
National ID:	784-1988-8280488-7	Service Date:	24-Sep-2024	Radiology:	Covered
		Patent's Tel No:	0554121082		
Policy Holder:		Threshold Limit:			
Payer Name:	AL SAGAR NATIONAL INSURANCE COMPANY	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	43524	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptom	
Complaint PC: FEVER COUGH FLU						DD	MM
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 : 101 T : 37.8 HR : RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J06.9	Acute upper respiratory infection, unspecified	
Secondary	R05	Cough	
Secondary	J02.9	Acute pharyngitis, unspecified	
Secondary	J00	Acute nasopharyngitis [common cold]	
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 occurred
☐ 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
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION		Phar
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)		Co.P
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular		Co.P
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour		Co.P
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE		Phar
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION		Phar
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION		Phar
Code	Generic	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 1Syrup 2 Time 7 Day(s) others
0788-106705-1171	(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	7	Take 1Tablets 2 Tim 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2Tim 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
<i>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>	<i>I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>
Treating Physician Name : AHSAN HUSSAIN	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 24-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 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 effects 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.