eASOAP FORM

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

Patent Name:	**UMAIR SHARIF**	Gender:	**Male**	Validity Between:	**01/01/2024 and 3**
Card No:	**5276-A895-D46E-2DD9**	DOB:	**8/4/1994 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1994-1409862-6**	Service Date:	**02-Oct-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0504914022**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44373**	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
Recurrent cough, chest pain, occasional difficulty breathing (especially at night and when using AC). Duration: Recurent Known asthmatic and known hypertensive Also plaque rashes on the right elbow joint. Low back pain		

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 : 130 T : 36.4 HR : RR : 18

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

Type	Code	Diagnosis
Primary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	I10	Essential (primary) hypertension
Secondary	J22	Unspecified acute lower respiratory infection
Secondary	L40.9	Psoriasis, unspecified
Secondary	M54.5	Low back 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/illne
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

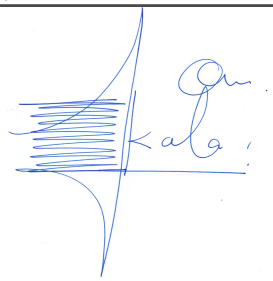
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	Consultation GP	General Consultation	60.0

Code	Generic	Duration	Instructions
0943-409101-0061	(URSODEOXYCHOLIC ACID (URSODIOL) : 250 MG) CAPSULES	60	Take 1Capsule 1Time(s) p Day(s) others
0027-179203-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1Time(s) pe Day(s) morning
0942-249004-1171	(POTASSIUM CITRATE : 1080MG (10MEQ)) TABLETS	60	Take 1Tablets 2Time(s) pe Day(s) after meal
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	28	Take 1Tablets 2 Time(s) pe Day(s) before meal
0281-367801-0431	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	30	Take 1Gel 2 Time(s) per D others
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Units 2Time(s) perD Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2Time(s) pe Day(s) after meal

○ 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 : 02-Oct-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.