

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	Muhammad Qaiser Dilbar Hussain	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	78B2-6A7B-51E8-171A	DOB:	3/20/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-3543583-8	Service Date:	07-Oct-2024	Radiology:	Covered
		Patent's Tel No:	0559577578		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44426	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 Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: Cough Duration: 10days Fever: 3days. chest pain and wheezing 2days. Known asthmatic and hypertensive. also c/o upper abdominal pain and belching Exam: Audible loud wheeze. Nebulization is advised.								
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 : 134	T : 37.2	HR : 90
			RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J45.21	Mild intermittent asthma with (acute) exacerbation			

Type	Code	Diagnosis
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	J22	Unspecified acute lower respiratory infection
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
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/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

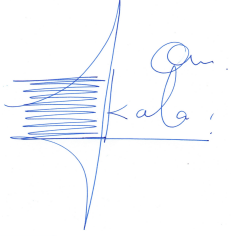
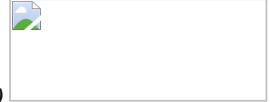
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	Co.Pay	52.0000
9	Consultation GP	General Consultation	60.0000

Code	Generic	Duration	Instructions
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Units 2 Time(s) per Day For 60 Day(s) others
0281-367801-0432	(CALCIPOTRIOL : 50 MCG/G) (BETAMETHASONE (AS DIPROPIONATE) : 0.5 MG/G) GEL	30	Take 1Gel 2 Time(s) per Day For 30 Day(s) others
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	14	Take 2sachet 2 Time(s) per Day For 14 Day(s) after meal
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	56	Take 1Tablets 1Time(s) perDay For 56 Day(s) before meal
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) evening
0006-264101-0791	(FLUTICASONE : 250 MCG) (SALMETEROL (AS XINAFOATE) : 50 MCG) POWDER FOR INHALATION	60	Take 1Puff 2 Time(s) per Day For 60 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2Time(s) perDay 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 : 07-Oct-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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