

eASOAP FORM


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

Patent Name:	Muhammad Faraz Muhammad Irshad	Gender:	Male	Validity Between:	13/09/2024 and 31/12/2026
Card No:	784-1989-5054821-8	DOB:	2/5/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1989-5054821-8	Service Date:	07-Oct-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0557854667		
Payer Name:	ENAYA	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44427	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
PC: Headache, cough, fever, breathlessness and body pains.								
Duration: 5days.								
Known asthmatic.								
Exam: Rhochi.								
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 : 120		T : 37.6		HR : 68		RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	J22	Unspecified acute lower respiratory infection									

Type	Code	Diagnosis
Secondary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	K29.00	Acute gastritis without bleeding
Secondary	K59.00	Constipation, unspecified
Secondary	M54.5	Low back pain
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

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:		

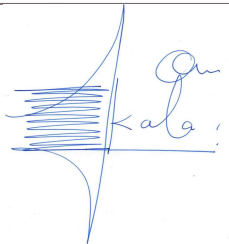
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	Consultation GP	General Consultation	60.0000

Code	Generic	Duration	Instructions
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	15	Take 2sachet 2 Time(s) per Day For 15 Day(s) after meal
0086-225101-2091	(POTASSIUM CHLORIDE : 46.6 MG) (POLYETHYLENE GLYCOL : 13.125 G) (SODIUM BICARBONATE : 178.5 MG) (SODIUM CHLORIDE : 350.7 MG) ORAL POWDER	15	Take 1sachet 3 Time(s) per Day For 15 Day(s) after meal
0205-290301-0391	(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening
0188-232401-0391	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0005-119803-1172	(PREDNISOLONE : 20 MG) TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) evening
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	56	Take 1Tablets 1Time(s) perDay For 56 Day(s) evening
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Units 2 Time(s) per Day For 60 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 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 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 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.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
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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