

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AHMED RAAFAT ABDELSALAM MOHAMED	Gender:	Male	Validity Between:	03/04/2024 and 02/04/2025
Card No:	5EC0-5945-655B-A461	DOB:	6/4/1980 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1980-5375264-2	Service Date:	16-Oct-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971502904116		
Payer Name:	ORIENT UNB TAKAFUL P.J.S.C.	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	36508	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: Flu symptoms, nasal congestion and pain in throat.								
Duration: 2days								
No cough								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 117 T : 37.7 HR : 75 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J01.00	Acute maxillary sinusitis, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	J30.9	Allergic rhinitis, unspecified					

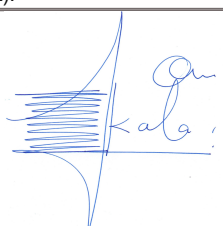
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:

☐ 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
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	4	Take 2Tablets 2 Time(s) per Day For 4 Day(s) after meal
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	6	Take 1Tablets 1 Time(s) per Day For 6 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal
0005-119803-1172	(PREDNISOLONE : 20 MG) TABLETS	7	Take 1Tablets 1Time(s) perDay For 7 Day(s) evening
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others

☐ 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 benefets. 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 : 16-Oct-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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