

eASOAP FORM


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

Patent Name:	ABEL SIMON VAN IGHEM	Gender:	Male	Validity Between:	03/07/2024 and 02/07/2025
Card No:	BAE0-BAD7-C9CE-A1E7	DOB:	5/7/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-1804439-7	Service Date:	19-Oct-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0527044418		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44550	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: FEVER								
SORETHROAT								
EPIGASTRIC PAIN								
COLD								
BLOATING								
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 : 140		T : 38.4	HR : 120	RR
				: 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected								
INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Primary	J06.9	Acute upper respiratory infection, unspecified						

Type	Code	Diagnosis
Secondary	R10.13	Epigastric pain
Secondary	R09.81	Nasal congestion
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R14.0	Abdominal distension (gaseous)
Secondary	J20.9	Acute bronchitis, unspecified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

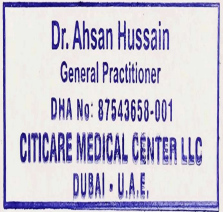
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
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.Pay	15.0000
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
9.01	Follow-up consultation	General Consultation	0.0000

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0005-128802-1971	(XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) LIQUID FOR SPRAY (NASAL)	7	Take 1Spray 3 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day 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 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 : AHSAN HUSSAIN		
Tel / Fax (important):		
<i>Signature & Stamp</i>   <i>Patient's Signature(Parent if minor)</i> 		
Date :		
Date : 19-Oct-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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