

eASOAP FORM

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

Patent Name:	SHANZEY HASSAN	Gender:	Female	Validity Between:	14/06/2024 and 2
Card No:	B872-9056-210E-E836	DOB:	2/3/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansa MEDGULF
National ID:	784-1987-3035760-9	Service Date:	01-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0523904547		
Policy Holder:		Threshold Limit:			
Payer Name:	DUBAI NATIONAL INSURANCE AND REINSURANCE CO	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44755	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptom	
Complaint CO DRY cough pain in throat both toe nail infection constipation 26th oct 2024 oe chest is congested no added sounds restless						DD	MM
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 : 100 RR : 18	T : 36.7	HR :
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	C84.00	Mycosis fungoides, unspecified site
Secondary	R05	Cough
Secondary	J45.909	Unspecified asthma, uncomplicated
Secondary	K56.41	Fecal impaction

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

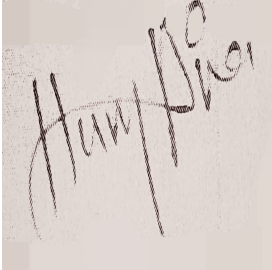
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occurred
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type
9	GP Consultation	General Consultat
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
0188-135906-2441	PULMICORT	Pharmacy
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
1291-170801-1161	(LACTULOSE : 66.7%) SYRUP	1	Take 30 ml at night
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	1	Take 10ML 3 Time(s) per Day Fo meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablet at night
0195-395404-0391	(MONTELUKAST (AS SODIUM : 10 MG FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day others
2104-140201-1452	(FLUCONAZOLE : 150 MG CAPSULES (HARD GELATIN	5	Take 1Tablets 1 Time(s) per Wee 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	
<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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>	
Treating Physician Name : Humaira			
Tel / Fax (important):			
Signature & Stamp 		 Patient's Signature(Parent if minor)	
Date :		Date : 01-Nov-2024	
Note: Claims must be submitted 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 effects 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.