eASOAP FORM

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

Patent Name:	**SAEED ALI MOHAMMAD ALI BILAL**	Gender:	**Male**	Validity Between:	**01/01/2024 and 3**
Card No:	**D0E8-D4B6-ED26-84F4**	DOB:	**8/25/2013 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-2013-4715162-9**	Service Date:	**01-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0508700446**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39915**	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 Symptom**	
Complaint	DD	MM
co dry coughing chest burning running nose 30th oct 2024 oe chest is congested no added sounds restless		

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 : 90 T : 36.8 HR : RR : 18

Assessment/Diagnosis : ○ Acute ○ Chronic ○ Confirmed ○ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R05	Cough

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/illne
○ 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
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-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy
9	GP Consultation	General Consultat
9	Consultation GP	General Consultat
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 orintermittent positive pressure breathing (IPPB) device	Co.Pay

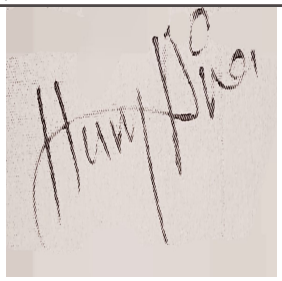
Code	Generic	Duration	Instructions
4266-107904-1161	(IBUPROFEN : 100 MG/5ML) SYRUP	1	take 10ml as per needed
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	1	Take 10ml at night for 5 night
0102-169701-1161	(AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP	5	Take 10ML 3 Time(s) per Day after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated Costs

Is the following required	○ Surgery:	○ Endoscopy:
	○ Physiotherapy:	○ Other Procedures:
		If yes please specify

Is In-patient Required ? Length of Stay	Indicate Provider

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	*I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managemer*

this case.	*responsibility of doctor and the patent.*
Treating Physician Name : **Humaira**	
Tel / Fax (important):	
Signature & Stamp  	***Patient's Signature(Parent if minor)***
Date :	Date : 01-Nov-2024
Note: Claims must be submited 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 efects 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.