

eASOAP FORM

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

Patent Name:	ROSE NAGAWA	Gender:	Female	Validity Between:	09/02/2024 and
Card No:	61E9-BF2D-34A4-55F9	DOB:	10/15/1982 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ans MEDGULF
National ID:	784-1982-7406049-4	Service Date:	02-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0567826456		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	38848	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptom	
Complaint						DD	MM
pc: fever							
weakness							
flu sorethroat							
low back pain							
dizziness							
Past Medical Surgical History?						Date of Symptom	
☐ Yes						DD	MM
☐ No							
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 : 110	T : 37	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	J00	Acute nasopharyngitis [common cold]
Secondary	R50.9	Fever, unspecified
Secondary	M54.5	Low back pain
Secondary	M62.830	Muscle spasm of back
Secondary	E86.0	Dehydration
Secondary	M62.81	Muscle weakness (generalized)

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

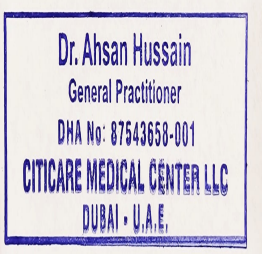
CPT Code	Treatment	Type
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
9	GP Consultation	General Consultation
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
0005-149902-1021	CLOFEN	Pharmacy
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay F evening
0278-107902-0391	(IBUPROFEN : 400 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day after meal

Code	Generic	Duration	Instructions
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2Time(s) perDay F meal

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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 benefets. Medical managemer responsibility of doctor and the patent.</i>	
Treating Physician Name : AHSAN HUSSAIN			
Tel / Fax (important):			
 Signature & Stamp 		 Patient's Signature(Parent if minor)	
Date :		Date : 02-Nov-2024	
Note: Claims must be submitted along with supporting 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.