eASOAP FORM

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

Patent Name:	**MUHAMMAD SHAH SALAAR RATHORE NADEEM YOUSAF**	Gender:	**Male**	Validity Between:	**25/10/2024 and 24/10/2025**
Card No:	**DC0F-465F-9F44-B5AD**	DOB:	**12/2/2012 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2012-4620482-6**	Service Date:	**11-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0508946099**		
Policy Holder:		Threshold Limit:			
Payer Name:	**TAKAFUL EMARAT**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37699**	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 PC: SOB, wheezing. Symptoms were relieved by use of ventolin Had been referred to pediatric pulmonologist who requested for CT scan of the chest. CT report however came yesterday and it's normal. There is no fever.	DD	MM	YYYY

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 : 0 T : 36.5 HR : 100 RR : 18

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

Type	Code	Diagnosis
Primary	J20.9	Acute bronchitis, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R06.2	Wheezing
Secondary	R06.00	Dyspnea, 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
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0005-119805-1172	(PREDNISOLONE : 5 MG TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others
1541-290302-0391	(LEVOCETIRIZINE (DIHCL OR HCL : 5MG FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) evening
4874-125821-3801	(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	5	Take 2Spray 4 Time(s) per Day For 5 Day(s) others
1700-704301-0791	(FLUTICASONE FUROATE : 100 MCG) (UMECLIDINIUM : 62.5 MCG) (VILANTEROL : 25 MCG) POWDER FOR INHALATION	60	Take 2Puff 1 Time(s) per Day For 60 Day(s) evening
5790-272103-3782	(BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) DRY POWDER INHALER	60	Take 2Puff 1 Time(s) per Day For 60 Day(s) evening

○ 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	Estimate Cost
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 this case.	*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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
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 : 11-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 reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.