

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
Policy Holder:		Patent's Tel No:	0508946099		
Payer Name:	TAKAFUL EMARAT	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	37699	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

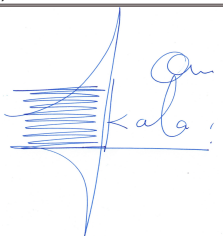
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: SOB, wheezing. Symptoms were relieved by use of ventolin Had been referred to pediatric pulmonologist who requested for CT scan of the chest. CT report however came yesterday and it's normal. 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		
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:	DD	MM	YYYY
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:		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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>	
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 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 reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse effects 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.