eASOAP FORM

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

Patent Name:	**ROMEO XAVIER CAPA**	Gender:	**Male**	Validity Between:	**01/04/2024 and 3**
Card No:	**513F-E206-A699-DB35**	DOB:	**7/29/2017 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-2017-0587248-5**	Service Date:	**13-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0561141881**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44903**	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
Pain in throat, cough, redness of both eyes and purulent discharge from both eyes. Duration 1 day (12/11/2024).		

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 : 0 T : 36.5 HR : RR : 24

Assessment/Diagnosis : ○ Acute ○ Chronic ○ Confirmed ○ Suspected

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	H10.023	Other mucopurulent conjunctivitis, bilateral
Secondary	J03.90	Acute tonsillitis, unspecified
Secondary	R05	Cough
Secondary	R09.81	Nasal congestion

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	Price
9	GP Consultation	General Consultation	25.0

Code	Generic	Duration	Instructions
0102-106704-1161	(CHLORPHENIRAMINE : 0.75 MG/5 ML) (PARACETAMOL : 120 MG/5ML) (PSEUDOEPHEDRINE : 15 MG/5ML) SYRUP	5	Take 5ML 2 Time 5 Day(s) others
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	10	Take 5ML 1 Time 10 Day(s) others
0031-103204-0371	(CIPROFLOXACIN : 0.3%) EYE DROPS	5	Take 2Drops 4 Ti For 5 Day(s) oth
0027-128801-1971	(XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL)	5	Take 2Spray 4 Ti For 5 Day(s) oth
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 10ML 3 Tin For 5 Day(s) oth
0135-142903-1112	(CEFIXIME : 100 MG/5ML) SUSPENSION	6	Take 10ML 1 Tin For 6 Day(s) oth

○ 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 this case.	*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 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 : 13-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
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doctors.