

eASOAP FORM

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

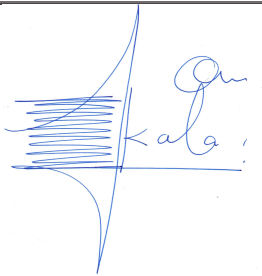
Patent Name:	ROMEO XAVIER CAPA	Gender:	Male	Validity Between:	01/04/2024 and 31/03/2025
Card No:	513F-E206-A699-DB35	DOB:	7/29/2017 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ansar) MEDGULF
National ID:	784-2017-0587248-5	Service Date:	13-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0561141881		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	44903	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptom	
Complaint Pain in throat, cough, redness of both eyes and purulent discharge from both eyes. Duration 1 day (12/11/2024).						DD	MM
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/illness occurred
☐ 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
Medications			
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 Times For 5 Day(s) others
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	10	Take 5ML 1 Time For 10 Day(s) others
0031-103204-0371	(CIPROFLOXACIN : 0.3%) EYE DROPS	5	Take 2Drops 4 Times For 5 Day(s) oth
0027-128801-1971	(XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) LIQUID FOR SPRAY (NASAL)	5	Take 2Spray 4 Times For 5 Day(s) oth
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 10ML 3 Times For 5 Day(s) oth
0135-142903-1112	(CEFIXIME : 100 MG/5ML) SUSPENSION	6	Take 10ML 1 Time For 6 Day(s) oth
☐ 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			
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 hereby authorize any Healthcare Provider, Insurer, Employer or other to release any informaton regarding my medical conditon and history for the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.	
Treating Physician Name : Enomen Goodluck			

Tel / Fax (important):	
 <i>Signature & Stamp</i> Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 <i>Patient's Signature(Parent if minor)</i> Date : 13-Nov-2024
Date :	
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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