

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MOHAMMAD AMEEN AL KORDI AMEEN AL KORDI	Gender:	Male	Validity Between:	15/01/2024 and 14/01/2025
Card No:	2AF6-99C0-D1D4-F703	DOB:	7/14/2008 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2008-6817519-9	Service Date:	19-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0553303607		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44949	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

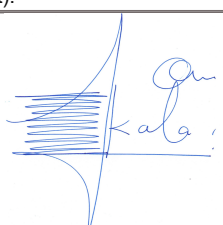
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: Pain in throat, cough, nasal congestion, running nose and pain in the nasal bridge and forehead								
Duration: 4days (13/11/2024).								
There is no fever,								
Not hypertensive and not diabetic and has no other medical condition of note								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						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 : 110 T : 36.8 HR : 78 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J01.10	Acute frontal sinusitis, unspecified			
Secondary	R09.81	Nasal congestion			
Secondary	R07.0	Pain in throat			

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		
2027-560101-0392	(IBUPROFEN : 150 MG (PARACETAMOL : 500 MG FILM COATED TABLETS	4	Take 2Tablets 2 Time(s) per Day For 4 Day(s) after meal		
5253-649501-3851	(MOMETASONE FUROATE (AS MONOHYDRATE : 50 MCG/DOSE NASAL SPRAY	5	Take 2Spray 2 Time(s) per Day For 5 Day(s) others		
0005-116801-1162	(SODIUM CITRATE : 57 MG/5ML (AMMONIUM CHLORIDE : 131.5 MG/5 ML (MENTHOL : 1.1 MG/5 ML (DIPHENHYDRAMINE : 13.5 MG/5ML SYRUP	7	Take 10ML 2 Time(s) per Day For 7 Day(s) after meal		
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal		
0097-116207-0392	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal		
0005-119805-1172	(PREDNISOLONE : 5 MG TABLETS	7	Take 2Tablets 1 Time(s) per Day For 7 Day(s) after meal		
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal		
☐ 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 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 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.			
Treating Physician Name : Enomen Goodluck					
Tel / Fax (important):					
 Signature & Stamp 		 Patient's Signature(Parent if minor)			
Date :		Date : 19-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 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

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