eASOAP FORM

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

Patent Name:	**ZAREESH KHAN FAHEEM KHAN**	Gender:	**Female**	Validity Between:	**04/09/2024 and 03/09/2025**
Card No:	**2A81-2C78-D795-CF12**	DOB:	**12/23/2021 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2021-9783061-9**	Service Date:	**20-Nov-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0569200125**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**36696**	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: COUGH 1 DAY 20/11/2024 FEVER 1 DAYS FLU 1 DAY			

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 : 90 T : 34.2 HR : 87 RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R09.81	Nasal congestion
Secondary	R06.7	Sneezing
Secondary	R05	Cough
Secondary	J21.9	Acute bronchiolitis, 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
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800

Code	Generic	Duration	Instructions
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	7	Take 1Solution 2 Time(s) per Day For 7 Day(s) others
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	7	Take 5 ML Syrup 2 Time(s) per Day For 7 Day(s) others
0027-128801-2021	(XYLOMETAZOLINE HYDROCHLORIDE : 0.05%) NASAL DROPS	5	Take 2Drops 2 Time(s) per Day For 5 Day(s) others
0252-127401-0851	(AZITHROMYCIN : 200 MG/5ML) POWDER FOR SUSPENSION	5	Take 5 ML 1 Time(s) per Day For 5 Day(s) after meal
0005-106604-1162	(PARACETAMOL : 120 MG/5ML) SYRUP	5	Take 5ML 3 Time(s) per Day For 5 Day(s) after meal
0090-265903-0081	(MONTELUKAST : 4 MG) CHEWABLE TABLETS	14	Take 1Tablets 1Time(s) perDay For 14 Day(s) after meal

○ 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 : **AHSAN HUSSAIN**		
Tel / Fax (important):		
Signature & Stamp Dr. Ahsan Hussain General Practitioner DHA No: 87543658-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 20-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.