# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **ALI IMRAN RIZVI** | Gender: | **Male** | Validity Between: | **18/12/2023 and 17/12/2024** |
| Card No: | **788E-DD5D-9965-77A0** | DOB: | **10/16/1983 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1983-2964974-7** | Service Date: | **20-Nov-2024** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0585342352** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **26250** | 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: Chronic cough for the past 15days.<br>Duration: 5/11/2024.<br>Associated with hoarsness of voice, and difficulty with breathing.<br>Takes tobacco (shisha).<br>Not hypertensive and not diabetic and not asthmatic and has no other medical condition of note<br>Chest: widespread rhonchi on all lung field. | | | |

| **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 : 120 T : 36.4 HR : 92 RR : 18 |
|---|---|

**Assessment/Diagnosis :** ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | J20.9 | Acute bronchitis, unspecified |
| Secondary | R06.00 | Dyspnea, unspecified |
| Secondary | R05 | Cough |
| Secondary | K21.9 | Gastro-esophageal reflux disease without esophagitis |
| Secondary | J42 | Unspecified chronic bronchitis |

**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 |
|---|---|---|---|
| 86140 | C-reactive protein; | Lab | 15.0000 |
| 85025 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count | Lab | 20.0000 |
| 0006-402803-2071 | VENTOLIN NEBULES | Pharmacy | 1.5300 |
| 0188-135906-2441 | PULMICORT | Pharmacy | 10.4800 |
| 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 |
| 9 | GP Consultation | General Consultation | 25.0000 |

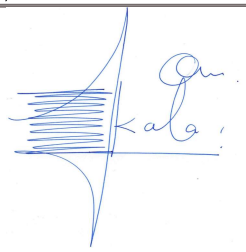
| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0188-232401-0391 | (ESOMEPRAZOLE : 40 MG FILM COATED TABLETS | 14 | Take 1Tablets 1 Time(s) per Day For 14 Day(s) evening |
| 1111-183202-0391 | (FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS | 30 | Take 1Tablets 1Time(s) perDay For 30 Day(s) evening |
| 0097-127405-0392 | (AZITHROMYCIN : 500 MG) FILM COATED TABLETS | 5 | Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal |
| 0027-265802-1161 | (BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP | 7 | Take 10ML 3 Time(s) per Day For 7 Day(s) others |
| 6534-101501-0271 | (ACETYLCYSTEINE : 200 MG EFFERVESCENT TABLETS | 7 | Take 1Tablets 3 Time(s) per Day For 7 Day(s) others |
| 0090-265901-1171 | (MONTELUKAST : 10 MG) TABLETS | 28 | Take 1Tablets 1Time(s) perDay For 28 Day(s) evening |
| 0005-119803-1171 | (PREDNISOLONE : 20 MG TABLETS | 7 | Take 1Tablets 1Time(s) perDay For 7 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*

*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE*

| | |
|---|---|
| *medically indicated & necessary for the management of this case.* | *for the purpose of determining insurance benefits. 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 : 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.