

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	KIMBERLEY CHARLIE BALL	Gender:	Female	Validity Between:	01/11/2024 and 31/10/2025
Card No:	FD34-EB9E-4EB0-D137	DOB:	7/4/1992 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1992-6670622-7	Service Date:	25-Nov-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0523843074		
Payer Name:	Islamic Arab Insurance Co. (P.S.C.)	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	39057	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

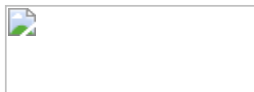
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started		
Complaint				DD	MM	YYYY
PC: Pain in throat, cough, and nasal congestions Duration: 3days. (21/11/2024) Had fever yesterday for which she has been on panadol and had no fever this morning. Known asthmatic, with recurrent iron deficiency anemia Not hypertensive and not diabetic does not smoke, alcohol.						
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 : 36.4	HR : 86	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J06.9	Acute upper respiratory infection, unspecified				
Secondary	J00	Acute nasopharyngitis [common cold]				
Secondary	J30.9	Allergic rhinitis, unspecified				
Secondary	R50.9	Fever, 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
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
Code	Generic	Duration	Instructions
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
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
0102-106704-1161	(CHLORPHENIRAMINE : 0.75 MG/5 ML) (PARACETAMOL : 120 MG/5ML) (PSEUDOEPHEDRINE : 15 MG/5ML) SYRUP	7	Take 10ML 2 Time(s) per Day For 7 Day(s) after meal
5253-649501-3851	(MOMETASONE FUROATE (AS MONOHYDRATE : 50 MCG/DOSE NASAL SPRAY	5	Take 2Spray 3 Time(s) per Day For 5 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 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 : 25-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 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.