

eASOAP FORM

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

Patent Name:	MOHAMMED ZOHAN IRSADH	Gender:	Male	Validity Between:	08/12/2023 and (
Card No:	D48E-1066-CC92-499B	DOB:	3/24/2021 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans: MEDGULF
Natonal ID:	784-2021-5144806-9	Service Date:	25-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0522488126		
Policy Holder:		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44566	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 Symptom	
Complaint PC: High grade fever: Duration: 2days (24/11/2024). Associated cough and generalized body pains. Previously presented for a febrile illness last month. Exam: Enlarged and hyperemic tonsils.			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 : 00	T : 39.4	HR :
	RR : 24		

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

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	J01.20	Acute ethmoidal sinusitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	E86.0	Dehydration

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:		

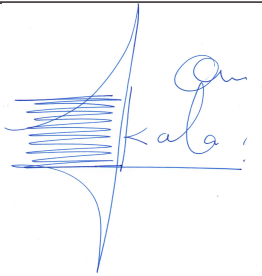
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type
9	GP Consultation	General Consultation
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0005-149902-1021	CLOFEN	Pharmacy
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION	Pharmacy
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
0135-142903-1112	(CEFIXIME : 100 MG/5ML) SUSPENSION	7	Take 7.5ML 1 Time(s) per Day For 7 Da

Code	Generic	Duration	Instructions
0005-106604-1161	(PARACETAMOL : 120 MG/5ML SYRUP	3	Take 10ML 3 Time(s) per Day For 3 Day
0152-119813-1161	(PREDNISOLONE : 3 MG/ML) SYRUP	7	Take 3ML 1 Time(s) per Day For 7 Day(
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	3	Take 5ML 3 Time(s) per Day For 3 Day(
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	7	Take 5ML 1 Time(s) per Day For 7 Day(

☐ 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>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>		<i>I hereby authorize any Healthcare Provider, Insurer, Employer or oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefsts. Medical managemer responsibility of doctor and the patent.</i>	
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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE: no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.