

eASOAP FORM


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

Patent Name:	ALLANNA KYRA VILLENA PABLEO	Gender:	Female	Validity Between:	20/02/2024 and 19/02/2025
Card No:	D4DD-DC6E-5611-D52E	DOB:	12/14/1995 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
National ID:	784-1995-8162954-2	Service Date:	26-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0547575345		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45032	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint Allergic to Ibuprofen evidence by facial edema. Generalized body pains, especially pain in the shoulders and neck. Pain is associated with weakness and muscle pains when touched Duration: 4days There is no fever, no cough. Has running nose however.						DD	MM	YYYY
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravidia: ☐ 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 : 150 : 18	T : 36.6	HR : 78	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	N39.0	Urinary tract infection, site not specified
Secondary	J06.9	Acute upper respiratory infection, unspecified
Secondary	M79.18	Myalgia, other site
Secondary	M60.9	Myositis, unspecified
Secondary	G43.009	Migraine w/o aura, not intractable, w/o status migrainosus
Secondary	E55.9	Vitamin D deficiency, 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:		

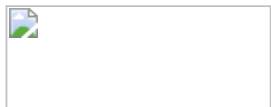
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400

Code	Generic	Duration	Instructions
0005-119805-1174	(PREDNISOLONE : 5 MG TABLETS	5	Take 2Tablets 1Time(s) perDay For 5 Day(s) evening
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
0252-389802-1171	(PARACETAMOL : 500 MG (PSEUDOEPHEDRINE HCL : 30 MG TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
5314-199803-1171	(SUMATRIPTAN : 100 MG TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening
0006-199804-1971	(SUMATRIPTAN : 10 MG) LIQUID FOR SPRAY (NASAL)	2	Take 2Spray 1 Time(s) per Day For 2 Day(s) evening

☐ 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>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 other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefets. Medical management is the sole 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 : 26-Nov-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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