

eASOAP FORM


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

Patent Name: ZUHAYR ALI	Gender: Male	Validity Between: 31/05/2024 and 30/05/2025
Card No: BB6C-DCA9-32A7-703C	DOB: 2/28/2018 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-2018-7082909-6	Service Date: 28-Nov-2024	Radiology: Covered
	Patent's Tel No: 0563097844	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 39625	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: fever started yesterday 26/11/2024				
flu				
cough				
body pain				
wheezing				
Past Medical Surgical History?		☐ Yes	☐ No	Date of Symptoms/illness started
				DD MM YYYY
Obs/Gyn Claims		Date of Symptoms/illness started		
☐ 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:				

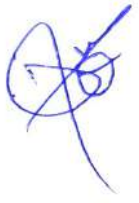
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :		Vital Signs : B/P : 0		T : 37.5	HR : 96	RR
		: 26				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J06.9	Acute upper respiratory infection, unspecified				
Secondary	J20.9	Acute bronchitis, unspecified				
Secondary	R50.9	Fever, unspecified				
Secondary	M54.5	Low back pain				

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		
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000		
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	Pharmacy	10.4800		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000		
Code	Generic	Duration	Instructions		
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	5	Take 1Solution 2 Time(s) per Day For 5 Day(s) others		
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others		
1541-290302-0391	(LEVOCETIRIZINE (DIHCL OR HCL) : 5MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) after meal		
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	10	Take 5ML 2 Time(s) per Day For 10 Day(s) after meal		
0139-116204-2151	(CLAVULANIC ACID : 57 MG/5ML) (AMOXICILLIN : 400 MG/5ML) POWDER FOR SYRUP	10	Take 7.5ML 2 Time(s) per Day For 10 Day(s) after meal		
0015-107901-0392	(IBUPROFEN : 200 MG) FILM COATED TABLETS	4	Take 1Tablets 2 Time(s) per Day For 4 Day(s) after meal		
0188-232403-0461	(ESOMEPRAZOLE : 10 MG) GRANULES FOR RECONSTITUTION	7	Take 1sachet 2 Time(s) per Day For 7 Day(s) others		
☐ 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 mentioned 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 benefits. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : AHSAN HUSSAIN					
Tel / Fax (important):					

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 28-Nov-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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