eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

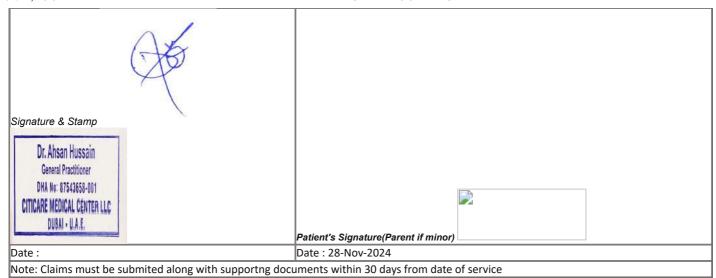
at the CITICARE MEDICAL CENTER LLC

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 Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-2018-7082909-6	Service Date: Patent's Tel No:	28-Nov-2024 0563097844	Radiology:	Covered
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) a	s described b	y the p	atent (Chief	Complaint):				Date of S	symptoms/ill	ness started
Complaint							DD	ММ	YYYY		
pc: fever sta	rted yesterda	y 26/11	/2024								
flu											
cough											
body pain											
'											
wheezing											
Past Medical S	Surgical Histo	rv?			○Yes		○ No		Date of S	ymptoms/il	lness started
ast Wiedical	Jaigicai i iisto	,, y .			O les				DD	ММ	YYYY
									Date of 9	 	Inoss started
Obs/Gyn Claims DD MM y						YYYY					
Para	☐ Gravida:		□ АВ:	LMP:	Marital Statu	s:	Marital Date:				
What date did t				• ,							
Is the Patient u	nder any type	of Treat	ment? O Ye	es O No	if yes, indicat	te what Asses	sment and since	when:			
OBJECTIVE / A	ASSESSMEN	T(To be	completed by	Physician)							
Clinical Findings: Vital Signs: B/P:0 T:3						7.5	HR : 96	RR			
Assessment/E IN	iagnosis : DICATE DIAG	O Ac		Chronic OM	O Confirme	ed OSusp	ected				
Туре		Code		Diagnosis							
Primary		J06.9		Acute upp	er respiratory	infection, un	specified				
Secondary		J20.9		Acute bror	ichitis, unspec	cified					
Secondary		R50.9		Fever, unsp	pecified						
Secondary	condary M54.5 Low back pain										
ACCIDENT/OC	CUPATIONAL	. Claim	Informaton	(complete	if claim is a re	esult of accid	ent or work rela	ted illne	ss/iniurv	<i>'</i>)	

O'res O No	724, TO.OT FIVE				Cillicout 6.0 - N	exicale Full	11			
NEDICAL PLAN Itemized Original invoices and Applicable Nedical Prescriptions Reports Results must be enclosed to constitution	IACCIDENT OF HINESS OHE TO WORK?				Describe how the accident or work related injury/illness occur:					
Treatment Trea	○ Yes ○ No		○Yes	○No	Ì					
Price Pric	Date of accident	or beginning of illn	ess:							
9 GP Consultation General Consultation 25.00 2190-106618- PARAFUSIV IV. 10MG/ML-[PARACETAMOL: 10 MG/ML] SOLUTION FOR INFUSION Pharmacy 8.400 94640 Pressuriated 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) 15.00 2638- PULMICORT Pharmacy 10.41 26372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 10.00 26372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 10.00 26372 DEXAMETHASONE SODIUM PHOSPHATE-[DEXAMETHASONE: 4 MG/ML] SOLUTION FOR Pharmacy 2.34 26385 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour 2.34 26391 ORDINATE 10.00 26391 ORDINATE 10.00 26491 ORDINATE 2.34 2640 ORDINATE 2	MEDICAL PLAN I	temized Original In	voices and Applical	ble Prescription	s / Reports / Resu	ults must be	enclosed to	consider claim		
Consultation Consultation Consultation 25.00	CPT Code	Treatment						Туре	Price	
106618- PARAFUSIV LV. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.400 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 induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with an aerosol generator, nebulizer, metered dose induction for diagnostic proposes (eg., with a eg., per page (eg., with a eg., per page (eg., with a eg., per page (eg., per page (9 (GP Consultation							25.000	
induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device) Pharmacy 10.41 10.42 10.42 10.42 10.42 10.42 10.42 10.42 10.42 10.42 10.42 10.43 10	106618- I	PARAFUSIV I.V. 10M	1G/ML-(PARACETAI	MOL : 10 MG/N	1L) SOLUTION FOI	R INFUSION		Pharmacy	8.4000	
135906- 2441 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR pharmacy 2.34t intramuscular DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR pharmacy 2.34t up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion intravely prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion intravely prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravenous infusion intravely prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour intravely prophylaxis, or diagnosis intravely prophylax	94640 i	induction for diagn		15.000						
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DEXAME HASONE SODIUM PHOSPHAIE-(DEXAME HASONE : 4 MG/ML) SOLUTION FOR pharmacy 2.34i 1022 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour 2.34i 107704-			ylactic, or diagnost	ic injection (spe	ecify substance or	r drug); subc	cutaneous or Co.Pay 10.			
Up to 1 hour O195- O195- O197- O297 O298 O298	122107-		SODIUM PHOSPHA	TE-(DEXAMETH	1L) SOLUTIO	N FOR Pharmacy 2.34				
Code Generic BudeSonide : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION 5 Take 1Solution 2 Time(s) per Day For 5 Day(s) others	4h3h5		n, for therapy, prop	ohylaxis, or diag	gnosis (specify sul	ostance or d	rug); initial,	Co.Pay	40.000	
CETIRIZINE HCL: 10 MG) FILM COATED TABLETS Take 1Tablets 1 Time(s) per Day For 5 Day(s) others	107704-	·							48.500	
2441 (BUDESONIDE : 0.23 MG/ML) SUSPENSION FOR NEBULIZATION 5 Day(s) others 0195-123701- (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others 1541-290302- (LEVOCETIRIZINE (DIHCL OR HCL) : 5MG) FILM COATED TABLETS 10 Take 1Tablets 1Time(s) per Day For 10 Day(s) after meal 0005-114501- (AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE) 10 Take 5ML 2 Time(s) per Day For 10 Day after meal 0139-116204- (CLAVULANIC ACID : 57 MG/5ML) (AMOXICILLIN : 400 MG/5ML) 10 Take 7.5ML 2 Time(s) per Day For 10 Day(s) after meal 0015-107901- (IBUPROFEN : 200 MG) FILM COATED TABLETS 4 Tablets 2 Time(s) per Day For 4 Day(s) after meal 0188-232403- (ESOMEPRAZOLE : 10 MG) GRANULES FOR RECONSTITUTION 7 Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others O Pharmacy: Estmated Costs	Code	Generic				Duration	Instruction	s		
Day(s) others	(RITI) ESCONITION OF MICE/MILL STISSE			PENSION FOR N						
Day(s) after meal		(CETIRIZINE HC	L : 10 MG) FILM CC	OATED TABLETS					y For 5	
2481 (AMBROXOL: 15 MG/SML) SYROP (SUGAR FREE) 10 after meal 0139-116204- 2151 (CLAVULANIC ACID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 2151 POWDER FOR SYRUP 0015-107901- 0392 (IBUPROFEN: 200 MG) FILM COATED TABLETS 0188-232403- 0461 (ESOMEPRAZOLE: 10 MG) GRANULES FOR RECONSTITUTION 7 Take 1sachet 2 Time(s) per Day For 7 Day(s) others Pharmacy: Estmated Costs Surgery: Estmated Costs Surgery: Endoscopy: 9 Physiotherapy: Other Procedures: If yes please specify Indicate Provider Estimate Cost 1 hereby certfy that all informaton mentoned are correct in that the medical services shown on this form were redically indicated & necessary for the management of his case. Teating Physician Name: AHSAN HUSSAIN	10 .1 250002	(LEVOCETIRIZIN	IE (DIHCL OR HCL)	: 5MG) FILM CC						
2151 POWDER FOR SYRUP 0015-107901- 0392 (IBUPROFEN: 200 MG) FILM COATED TABLETS 4 Take 1Tablets 2 Time(s) per Day For 4 Day(s) after meal 10 Day(s) after meal 4 Take 1Tablets 2 Time(s) per Day For 4 Day(s) after meal 7 Take 1sachet 2 Time(s) per Day For 7 Day(s) others Pharmacy: Estmated Costs Surgery: Physiotherapy: Physiotherapy: If yes please specify Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXTCA for the purpose of determining insurance benefts. Medical management is the screeponsibility of doctor and the patent.		(AMBROXOL : 1	.5 MG/5ML) SYRUP	(SUGAR FREE)	IGAR FREE			Time(s) per Day For 10 Day(s		
Day(s) after meal Day(s) after meal Day(s) after meal O188-232403- O461 (ESOMEPRAZOLE : 10 MG) GRANULES FOR RECONSTITUTION 7 Take 1sachet 2 Time(s) per Day For 7 Day(s) others Day(s) after meal Take 1sachet 2 Time(s) per Day For 7 Day(s) others Day(s) after meal Take 1sachet 2 Time(s) per Day For 7 Day(s) others Day(s) after meal Day(s) after meal after pounds Day(s) after meal after po			(AMOXICILLIN :							
O461 Carry Carry	HELIPROFENT JOO MG1 FILM COATE			TED TABLETS		4	Day(s) after meal			
Surgery: Physiotherapy: If yes please specify Indicate Provider Indicate Provider Estimate Cost A thereby certfy that all informaton mentoned are correct A that the medical services shown on this form were A thereby certfy indicated & necessary for the management of his case. Thereby certfy indicated & necessary for the management of his case. Thereby certfy that all informaton mentoned are correct to release any informaton regarding my medical condition and history to NEXTCA for the purpose of determining insurance benefits. Medical management is the solution responsibility of doctor and the patent.	II (ESOMEDRAZOTE : 10 MG) GRANI			JLES FOR RECO	NSTITUTION	7				
Sthe following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Estimate Cost thereby certfy that all informaton mentoned are correct to that the medical services shown on this form were the dically indicated & necessary for the management of his case. The physiotherapy: Other Procedures: Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXTCA for the purpose of determining insurance benefits. Medical management is the solution responsibility of doctor and the patent. The purpose of determining insurance benefits and the patent.	O Pharmacy:		Estmated Costs		Caboratory	/ Radiology	: Est	tmated Costs		
If yes please specify Indicate Provider Estimate Cost thereby certfy that all informaton mentoned are correct to that the medical services shown on this form were medically indicated & necessary for the management of his case. The please specify Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXTCA for the purpose of determining insurance benefts. Medical management is the so responsibility of doctor and the patent.			O Surgery:		○ Endoscopy:					
Indicate Provider Estimate Cost thereby certfy that all informaton mentoned are correct to that the medical services shown on this form were medically indicated & necessary for the management of his case. The purpose of determining insurance benefits. Medical management is the solution responsibility of doctor and the patent. The purpose of determining insurance benefits in the patent. The purpose of determining insurance benefits in the patent.			O Physiotherapy	:						
that the medical services shown on this form were redically indicated & necessary for the management of his case. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizate to release any informaton regarding my medical condition and history to NEXtCA for the purpose of determining insurance benefits. Medical management is the solution responsibility of doctor and the patent.					If yes please specify					
reating Physician Name : AHSAN HUSSAIN	hereby certfy the that the medic	hat all informaton r al services shown c	mentoned are corre on this form were	to release of	ithorize any Healt any informaton re pose of determini	thcare Provide garding my ing insurance	medical con	Employer or other C diton and history to	rganizaton NEXtCARE	
				responsibil	ity of doctor and	tne patent.				
el / Fax (important):	his case.	Namo : AUCAN !!!	IAIVSSI	I .						



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