eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the CITICARE MEDICAL CENTER LLC

Patent Name:	ISMAIL HUSSAIN	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	5776-C623-6997-89E8	DOB:	1/1/2022 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1985-8071537-7	Service Date:	28-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0527204222		
Policy Holder:		Threshold Limit:			
Payer Name:	DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	12872	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton:		Laboratory:	Covered
Referral No:					
Referred Service:					
SUBJECTIVE /	ASSESSMENT				

Symptom(s) as described	by the patent (Ch	ief Complai	nt):		Date o	of Sympton	ns/illness started		
Complaint							YYYY		
co fever on and off dry c		at 25th nov	. 2024						
	added sounds								
restless									
smoker									
					Date	of Sympto	 ms/illness started		
Past Medical Surgical Hi	istory?		○ Yes	○ No	DD	MM	YYYY		
Obs/Gyn Claims							Date of Symptoms/illness started		
	10.5	T. 100	14. 1. 1.0	N 1.15	DD	MM	YYYY		
Para Gravida:	AB:	LMP:	Marital Status:	Marital Date:					
What date did the Patient fir	rst feel same / simi	ar Symptom	(s) : dd mm yyyy				I		
Is the Patient under any type	e of Treatment?	Yes O	No if yes, indicate what	Assessment and since	when:				
OBJECTIVE / ASSESSMEN	NT(To be completed	d by Physicia	n)						
Clinical Findings :			Vital Sigi RR : 18	ns: B/P:120	T:36	Н	R : 86		
Assessment/Diagnosis : INDICATE DIA	O Acute GNOSIS NOT SYI	○ Chronic	Confirmed 0	Suspected					
Туре	Code	Diagno	Diagnosis						
Primary	J06.9	Acute	Acute upper respiratory infection, unspecified						
Secondary	J30.9	Allergi	Allergic rhinitis, unspecified						
Secondary	R05	Cough	Cough						
Secondary	R50.9	Fever,	Fever, unspecified						
Secondary	ondary K29.00 Acute gastritis without bleeding								
ACCIDENT/OCCUPAT	IONAL Claim I1	nformaton (complete if claim is a r	esult of accident or w	ork related i	illness/iniu	ırv)		

Accident or illness due to work?

Describe how the accident or work related injury/illness occur:

Injury due to road

accident?

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Price	○ Yes ○ No ○ Yes ○) No	_						
Code Generic General Consultation Duration Instructions Duration Duration Instructions Duration Instructions Duration Duration Instructions Duration Instructions Duration Dur	Date of accident or beginning of illness:											
Code Generic Duration Instructions Duration Instructions O005-116702-2481 (SUGAR FREE O005-107001- (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) 6 Take ITablet s per need CAZITHROMYCIN : 500 MG) FILM COATED TABLETS 5 Take ITablets Time(s) per Day For 5 Day(s) others O1391 (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 3 Take ITablets Time(s) per Day For 5 Day(s) others O1391 (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 3 Take ITablets Time(s) per Day For 5 Day(s) others O1391 (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 3 Take ITablets Time(s) per Day For 5 Day(s) others O1491	MEDICAL PLAN It	emized Or	igina	l Invoices a	nd Applica	ble Prescript	ions / Repor	ts / Results r	nust be enclo	sed to consid	der claim	
Code Generic Duration Instructions 0005-116702- (DIPHENHYDRAMINE : 12.5 MG/SML SYRUP 2481 (SUGAR FREE (SUGAR FREE (SUGAR FREE (SUGAR FREE (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) 6 Take 1Tablet as per need 4235-127405- (AZITHROMYCIN : 500 MG) FILM COATED TABLETS 5 Take 1Tablets 1 Time(s) per Day For 5 Day(s) others 0195-123701- (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 3 Take 1Tablets 1 Time(s) per Day For 3 Day(s) others 0195-123701- (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS 3 Take 1Tablets 1 Time(s) per Day For 3 Day(s) others Osurgery: Database of the following required Surgery: Dendoscopy: Estmated Costs Surgery: Dendoscopy: Dendoscopy: Physiotherapy: Dendoscopy: If ye splease specify	CPT Code Treatment						Type				Price	
ODS-116702-2481 (SUGAR FREE	9		GP C	Consultation	l		General Co	onsultation			25.0000	
ODS-116702-2481 (SUGAR FREE												
2481 GSUGAR FREE 1 Others	Code	Generic						Duration	Instruction	ıs		
CAPLETS 0 Take I Tablets as per need					: 12.5 MG	/5ML SYRU	P	1				
Other Catherina Catherin						AMOL: 500	MOL: 500 MG) 6			Take 1Tablet as per need		
OPharmacy: Estmated Costs OLaboratory / Radiology: Estmated Costs Surgery: Onther Procedures:		(AZITHROMYCIN : 500 MG) FILM				M COATED TABLETS		5				
Is the following required Surgery: Other Procedures: If yes please specify If yes please specify Indicate Provider Estimate Cost Indicate Provider Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXICARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Humaira Tel / Fax (important): DI. Humaira Numtaz Geneal Protitions OHA IN. \$415550402 CITICARE MORAL CENTRAL COST Patient'S Signature (Parent if minor) Date: Date: 28-Nov-2024							ADLETO			ets 1 Time(s)	per Day For 3 Day(s)	
Is In-patient Required? Length of Stay Indicate Provider Indicate Pr	O Pharmacy: Estmated Costs					Caboratory / Radiology: Es			Estmated Costs			
Is In-patient Required? Length of Stay Indicate Provider Indicate Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXICARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Or, Humaira Mumtaz General Practitioner DHA No. \$4555530-002 CITICARE HEDICAL CENTER LLC DUBAN-U.A.E. Patient's Signature(Parent if minor) Date: 28-Nov-2024	○ Surgery:			y:		○ Endoscopy:						
Is In-patient Required? Length of Stay Indicate Provider I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Dr. Humaira Mumtaz General Practitioner DRA ILE SISSSS-0102 CITICARE MEDICAL CENTER LLC DRAN - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date: 28-Nov-2024	Is the following required			O Physiotherapy:			Other Procedures:					
I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Ot. Humaira Muntaz General Practitioner DHA ID: \$415530-002 CITICARE HEDICAL CENTER LLC COURT. A.C. Signature (Parent if minor) Date: Date: 28-Nov-2024							If yes please specify					
I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Ot. Humaira Muntaz General Practitioner DHA ID: \$415530-002 CITICARE HEDICAL CENTER LLC COURT. A.C. Signature (Parent if minor) Date: Date: 28-Nov-2024	Laboration Description (C)				Indicate Provider					Estimate Cost		
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Tel / Fax (important): Dr. Humaira Muntaz General Practitioner DHA No. 54155500-002 CTTCARE MEDICAL CENTER LLC DUBAI-U.A.E. Patient's Signature(Parent if minor)												
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Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date:	this case.				responsibility of doctor and the patent.							
Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: 28-Nov-2024	Treating Physician Name : Humaira											
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	General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC											
Note: Claims must be submitted along with supporting documents within 30 days from date of service	CITICARE MEDICAL CENTER L	LC				Patient's Sig	nature(Parent					
	CITICARE MEDICAL CENTER L DUBAI - U.A.E.					Date : 28-N	ov-2024	t if minor)				

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 final opinion will be given by the NEXtCARE claims doctors.