

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Thani Hassan Ibrahim Karam Hassan	Gender:	Male	Validity Between:	01/01/2024 and 31/12/2026
Card No:	7DB1-1B3A-AA49-0FA3	DOB:	9/20/2016 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2016-4276204-7	Service Date:	28-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0507742012		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45058	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: Cough that is distressing and associated with vomiting, for which he has had over 4 episodes tdday.							
Duration: 1day (28/11/2024).							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					DD	MM	YYYY
Obs/Gyn Claims					Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ 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)

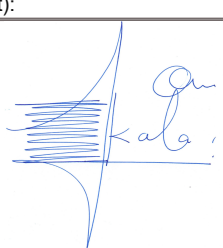
Clinical Findings :		Vital Signs : B/P : 00 T : 36.4 HR : 96 RR : 20	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J03.90	Acute tonsillitis, unspecified	
Secondary	R05	Cough	
Secondary	R11.10	Vomiting, unspecified	

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	Consultation GP	General Consultation	60.0000

Code	Generic	Duration	Instructions
5944-142903-0813	(CEFIXIME : 100 MG/5ML POWDER FOR RECONSTITUTION	5	Take 10ML 1 Time(s) per Day For 5 Day(s) after meal
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	5	Take 5ML 3 Time(s) per Day For 5 Day(s) after meal
1516-107904-1111	(IBUPROFEN : 100 MG/5ML) SUSPENSION	5	Take 5ML 3 Time(s) per Day For 5 Day(s) after meal
0252-389901-1161	(LORATADINE : 5 MG/5ML (PSEUDOEPHEDRINE SULPHATE : 60MG/5 ML SYRUP	5	Take 5ML 2 Time(s) per Day For 5 Day(s) after meal
0152-119813-1161	(PREDNISOLONE : 3 MG/ML) SYRUP	5	Take 5ML 1 Time(s) per Day For 5 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>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 benefths. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
<i>Signature & Stamp</i>  Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. <i>Patient's Signature(Parent if minor)</i> 		
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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