

eASOAP FORM

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

Patent Name:	MUHAMMAD SAQUIB MUHAMMAD SIDDIQ	Gender:	Male	Validity Between:	06/06/2024 and 0
Card No:	9B54-FC01-765D-1665	DOB:	1/2/1992 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansa MEDGULF
Natonal ID:	784-1992-3819613-5	Service Date:	29-Nov-2024	Radiology:	Covered
		Patent's Tel No:	0529821723		
Policy Holder:		Threshold Limit:			
Payer Name:	Islamic Arab Insurance Co. (P.S.C.	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45064	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 Symptom	
Complaint						DD	MM
co fever on and off dry cough pain in throat 4 months on and off august 2024							
oe							
chest is wheezing							
already taking montilukast							
restless smoker							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						DD	MM
☐ 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 : 105 RR : 18	T : 36	HR :
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R05	Cough
Secondary	R50.9	Fever, unspecified
Secondary	K29.00	Acute gastritis without bleeding

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 occurred
☐ 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

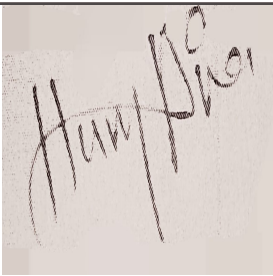
CPT Code	Treatment	Type
82785	Gammaglobulin (immunoglobulin); IgE	Lab
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)	Lab
9	GP Consultation	General Consultat
94640	Pressurized or nonpressurized inhalation 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
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy
86140	C-reactive protein;	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Tablets 2 Time(s) per Day(s) others
0219-533802-0342	(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) ENTERIC COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day(s) others

Code	Generic	Duration	Instructions
1516-148602-1171	(CLARITHROMYCIN : 500 MG TABLETS	7	Take 1Tablets 1 Time(s) per Day(s) others
2118-290301-0392	(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
	If yes please specify		

Is In-patient Required ? Length of Stay		Indicate Provider	
<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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefets. Medical managemer responsibility of doctor and the patent.</i>	
Treating Physician Name : Humaira			
Tel / Fax (important):			
Signature & Stamp  		 Patient's Signature(Parent if minor)	
Date :		Date : 29-Nov-2024	
Note: Claims must be submitted along with supporting documents within 30 days from date of service			

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE: no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the N doctors.