

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	OUSAMA AKKAD	Gender:	Male	Validity Between:	01/02/2024 and 31/01/2025
Card No:	19B4-8696-D4A0-8025	DOB:	10/22/1997 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1997-1123960-0	Service Date:	04-Dec-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0551567187		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45107	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
pc:fever								
flu								
sore throat								
body pain								
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 : 120 T : 37.9 HR : 78 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J00	Acute nasopharyngitis [common cold]			
Secondary	J20.9	Acute bronchitis, unspecified			
Secondary	M54.5	Low back pain			
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis			

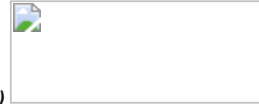
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)			
Accident or illness due to work?		Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No		☐ Yes ☐ No	
Date of accident or beginning of 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
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
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
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	Pharmacy	8.4000
0195-107704-0801	CEFTRIAZONE-TABUK IV-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
Code	Generic	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP	7	Take 1Syrup 2 Time(s) per Day For 7 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
☐ Surgery:		Estimated Costs	☐ Endoscopy:
☐ Physiotherapy:		☐ Other Procedures:	
Is the following required		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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>	
Treating Physician Name : AHSAN HUSSAIN			
Tel / Fax (important):			



Signature & Stamp



Patient's Signature(Parent if minor)



Date :

Date : 04-Dec-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 creation 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 effects 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.