

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: ABDULLAH ALI	Gender: Male	Validity Between: 21/02/2024 and 20/02/2025
Card No: 75EA-8385-50D5-BA2C	DOB: 2/8/2023 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-2023-1051980-0	Service Date: 11-Dec-2024	Radiology: Covered
	Patent's Tel No: 0551687187	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 41033	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: vomiting 11/12/2024				
fever				
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)

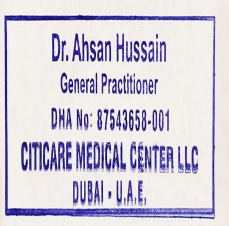
Clinical Findings :		Vital Signs : B/P : 00 T : 37 HR : 110 RR : 24			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J00	Acute nasopharyngitis [common cold]			
Secondary	J20.9	Acute bronchitis, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	R05	Cough			

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
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

Code	Generic	Duration	Instructions
5792-876901-1381	(GLUCOSE MONOHYDRATE : 3.2 G/200ML) (TRISODIUM CITRATE DIHYDRATE : 5.9 G/200ML) (SODIUM CHLORIDE : 0.35 G/200ML) (POTASSIUM CHLORIDE : 0.3 G/200ML) SOLUTION (ORAL)	7	Take 1Solution 1 Time(s) per Day For 7 Day(s) others
0031-168202-1111	(DOMPERIDONE : 1 MG/ML) SUSPENSION	7	Take 3 ml Syrup 3Time(s) perDay For 7 Day(s) before meal
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	7	Take 1Solution 2 Time(s) per Day For 7 Day(s) others
0788-106604-1111	(PARACETAMOL : 120 MG/5ML) SUSPENSION	7	Take 3 ml Syrup 3 Time(s) per Day For 7 Day(s) others
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	7	Take 3 ml Syrup 2Time(s) perDay For 7 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 benefits. 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 : 11-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 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 fnal opinion will be given by the NEXtCARE claims doctors.

