

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	SHYLA ROBERT CHENNATH DEVASSY	Gender:	Female	Validity Between:	05/12/2024 and 04/12/2025
Card No:	CFA5-17D0-1E04-776C	DOB:	10/4/1967 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1967-6679482-8	Service Date:	12-Dec-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0568387333		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45200	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

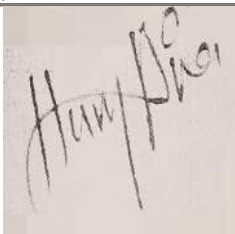
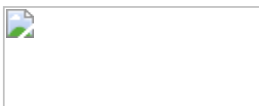
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
co diarrhoea 5 times nausea fever on and off 10th dec. 2024								
oe								
chest is clear no added sounds								
restless								
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 : 155 T : 36 HR : 80 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	A09	Infectious gastroenteritis and colitis, unspecified					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	R11.0	Nausea					
Secondary	R50.9	Fever, unspecified					

ACCIDENT/OCCUPATIONAL Claim Information (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		
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000		
9	GP Consultation	General Consultation	25.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000		
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000		
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		
Code	Generic	Duration	Instructions		
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Capsule 2 Time(s) per Day For 6 Day(s) others		
1795-502202-1451	(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	7	Take 1Capsule 3 Time(s) per Day For 7 Day(s) others		
0102-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others		
0195-116604-0391	(METRONIDAZOLE : 500 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others		
3114-482003-0391	(CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others		
☐ Pharmacy:		Estimated Costs		☐ Laboratory / Radiology:	
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 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 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.			
Treating Physician Name : Humaira					
Tel / Fax (important):					
 Signature & Stamp		 Patient's Signature(Parent if minor)			
					
Date :		Date : 12-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.