# eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **NADEEM KHAN HAKIM KHAN** | Gender: | **Male** | Validity Between: | **23/09/2024 and 22/09/2025** |
| Card No: | **7ECB-B800-04BA-1D0C** | DOB: | **1/1/1981 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1981-0295361-3** | Service Date: | **13-Dec-2024** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0556593294** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **45202** | 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 |
| No Complaints Found for Selected Appointment | | | | | |
| **Past Medical Surgical History?** | ○ Yes | ○ No | **Date of Symptoms/illness started** | | |
| | | | DD | MM | YYYY |
| | | | | | |
| Obs/Gyn Claims | | | **Date of Symptoms/illness started** | | |
| | | | DD | MM | YYYY |
| ☐ 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 : 130 T : 37.5 HR : 86 RR : 18 |
|---|---|

**Assessment/Diagnosis :** ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | J06.9 | Acute upper respiratory infection, unspecified |
| Secondary | R50.9 | Fever, unspecified |
| Secondary | J20.9 | Acute bronchitis, unspecified |
| Secondary | M79.10 | Myalgia, unspecified site |
| 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: | | |

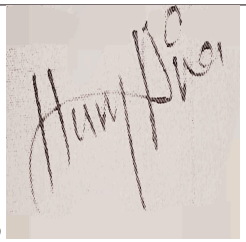
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

| CPT Code | Treatment | Type | Price |
|---|---|---|---|
| 9.01 | Follow-up consultation | General Consultation | 0.0000 |
| 96375 | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) | Co.Pay | 5.0000 |
| 87804 | Infectious agent antigen detection by immunoassay with direct optical observation; Influenza | Lab | 30.0000 |
| 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-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION | Pharmacy | 10.4800 |
| 96365 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour | Co.Pay | 40.0000 |
| 96372 | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | Co.Pay | 10.0000 |
| 0046-149902-0511 | Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule) | Pharmacy | 3.1000 |
| 0195-107704-0801 | CEFTRIAXONE-TABUK IV | Pharmacy | 48.5000 |
| 2190-106618-1001 | PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION | Pharmacy | 8.4000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0207-533801-1451 | (ESOMEPRAZOLE (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN | 7 | Take 1Capsule 2 Time(s) per Day For 7 Day(s) others |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | 5 | Take 1Tablet at night |
| 0097-127405-0391 | (AZITHROMYCIN : 500 MG FILM COATED TABLETS | 7 | Take 1Tablets 1 Time(s) per Day For 7 Day(s) others |
| 0005-107001-0051 | (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS | 6 | Take 1Tablets 2 Time(s) per Day For 6 Day(s) others |
| 0005-116702-2481 | (DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE | 30 | Take 10 ml 3 times in a day |

| ○ Pharmacy: | Estmated Costs | ○ Laboratory / Radiology: | Estmated 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 hereby certfy 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 benefts. 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 : 13-Dec-2024 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |

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