# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **NAWRAS MOHAMMAD ALKORDI** | Gender: | **Male** | Validity Between: | **15/01/2024 and 14/01/2025** |
| Card No: | **415F-B25D-B1C2-C2C4** | DOB: | **6/1/2003 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-2003-3262726-2** | Service Date: | **16-Dec-2024** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0588318592** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **38461** | 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: pain in throat,<br>Duration 3days.<br>Feeling of block ears (left).<br>Exam: wax impaction on the left ear..<br>Counselled to use waxol and then return after 5days for ear washout | | | |

| **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 : 177 T : 36 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 | R07.0 | Pain in throat |
| Secondary | R09.81 | Nasal congestion |
| Secondary | H61.23 | Impacted cerumen, bilateral |

**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 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS | 10 | Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal |
| 1516-107902-1171 | (IBUPROFEN : 400 MG TABLETS | 4 | Take 2Tablets 2 Time(s) per Day For 4 Day(s) after meal |
| 0252-185801-0391 | (DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS | 10 | Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal |
| 0355-163001-0241 | (DOCUSATE : 0.5% EAR DROPS | 3 | Take 2Drops 4 Time(s) per Day For 3 Day(s) others |

| ○ 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 : **Enomen Goodluck** | | |
| Tel / Fax (important): | | |
| *Signature & Stamp*<br>Dr. Enomen Goodluck Ekata<br>General Practitioner<br>DHA No: 28040827-001<br>CITICARE MEDICAL CENTER LLC<br>DUBAI - U.A.E. | ***Patient's Signature(Parent if minor)*** | |
| Date : | Date : 16-Dec-2024 | |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | | |

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