

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	SALMA SALAH NAJI AHMED AL BAHAL	Gender:	Female	Validity Between:	01/01/2024 and 31/12/2026
Card No:	0CF7-B8AF-F180-B7B7	DOB:	8/27/2022 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2022-5099410-4	Service Date:	17-Dec-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971503145470		
Payer Name:	DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20 %
Gatekeeper:	No	Patent's File No:	45244	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 fever on and off dry cough running nose 16th dec. 2024								
oe chest is congested 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:								

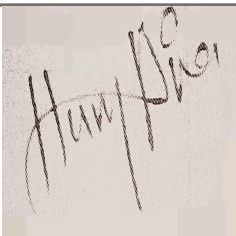
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :				Vital Signs : B/P : 00 T : 37.1 HR : 98	
				RR : 24	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J30.9	Allergic rhinitis, unspecified			
Secondary	R05	Cough			
Secondary	R50.9	Fever, unspecified			

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
0188-135906-2441	PULMICORT	Pharmacy	10.4800
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
9	GP Consultation	General Consultation	25.0000
Code	Generic	Duration	Instructions
4509-559803-1161	(THYMUS VULGARIS EXTRACT : 5G /100G) SYRUP	1	take 0.5 ml 3 times in a day
0205-123704-1631	(CETIRIZINE : 10 MG/ML) DROPS (ORAL)	1	Take 2 drops at night for 5 days
0139-116203-2151	(CLAVULANIC ACID : 31.25 MG/5ML) (AMOXICILLIN : 125 MG/5ML) POWDER FOR SYRUP	1	take 2ml once in a day
0005-106604-1162	(PARACETAMOL : 120 MG/5ML) SYRUP	1	take 2ml as per need
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
☐ Surgery:		Estimated Costs	☐ Endoscopy:
☐ Physiotherapy:		Estimated Costs	☐ 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 benefis. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Humaira		
Tel / Fax (important):		
Signature & Stamp  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) 		
Date :		
Date : 17-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 effects 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.