

eASOAP FORM



ADMINISTRATIVE

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

Patent Name: Marya Salah Naji Ahmed	Gender: Female	Validity Between: 01/01/2024 and 31/12/2026
Card No: 6EBB-489B-2D3D-D70C	DOB: 6/13/2021 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-2021-9992825-4	Service Date: 17-Dec-2024	Radiology: Covered
	Patent's Tel No: 0503145470	
Policy Holder:	Threshold Limit:	
Payer Name: DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 44962	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 co fever on and off dry cough 15th dec. 2024 oe chest is congested no added sounds restless						DD	MM	YYYY
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:								

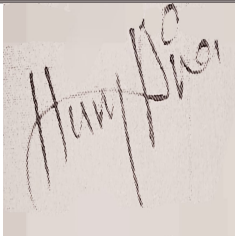
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :			Vital Signs : B/P : 00 T : 36.3 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
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	Co.Pay	52.0000
9	Consultation GP	General Consultation	60.0000
Code	Generic	Duration	Instructions
4509-559803-1161	(THYMUS VULGARIS EXTRACT : 5G /100G) SYRUP	1	Take 1ml 3times in a day
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	1	take 1.5 ml at night for 5 days
1695-510201-1161	(TRIKATU : 2.5 MG/5 ML) (ADHATODA VASICA : 20 MG/5ML) (GLYCYRRHIZA GLABRA : 20 MG/5ML) (ZINGIBER OFFICINALE : 5 MG/5ML) (OCIMUM SANCTUM : 20 MG/5ML) (SOLANUM XANTHOCARPUM : 6.25MG/5ML) (MENTHA SYLVESTRIS : 3 MG/5ML) SYRUP	1	take 1ml 3 times in a day
0139-116205-2151	(CLAVULANIC ACID : 28.5 MG/5 ML) (AMOXICILLIN : 200 MG/5ML) POWDER FOR SYRUP	1	take 2.5ml 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 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 benefsts. 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 : 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 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.