eASOAP FORM



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

Patent Name:	MOHAMMED HUDAN AHAMED HOSSAIN	Gender:	Male	Validity Between:	13/06/2024 and 12/06/2025
Card No:	792B-5FCF-2520-707E	DOB:	12/10/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1978-3632171-7	Service Date:	23-Dec-2024	Radiology:	Covered
		Patent's Tel No:	0551138109		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	34675	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred					
Service:					
SUBJECTIVE ASS	SESSMENT		<u> </u>		
Cumptom(a) as	described by the notent (C	hiaf Camplaint).			Data of Cumptoma/illness started

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:111 T:38 HR:100 RR : 18 Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary J06.9 Acute upper respiratory infection, unspecified Secondary J20.9 Acute bronchitis, 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? OBJECTIVE / Marital Status: Marital Date: Date: Acute what Assessment and since when: Code marital Date: No Mid Patient Status: Marital Date: Date: Acute profice description of the second since what Assessment and since when: Date: Acute profice description of the second since what Assessment and since when: Date: Acute profice description of the second since what Assessment and since when: Date: Acute profice description of the second since what Assessment and since what Assessment and since when: Date: Acute profice description of the second since what Assessment and since what As	Symptom(s) a	s described b	y the pa	atent (Chi	ef Complaint):				Date of	Symptoms/ill	ness started
Past Medical Surgical History? Yes										DD	ММ	YYYY
Past Medical Surgical History? Yes	pc: fever 22/	12/2024										
Past Medical Surgical History? Yes	flu											
Past Medical Surgical History? Oyes	cough											
Obs/Gyn Claims Date of Symptoms/illness started DD MM YYYY					Over		O N -		Date of	Symptoms/i	Iness started	
Obs/Gyn Claims	Past Medical S	Surgical Histo	ryr			Yes				DD	ММ	YYYY
Obs/Gyn Claims										Date of	 	Iness started
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Is the Patient under any type of Treatment?	Para	Gravida:		□ АВ:	LMP:	Marital Status	s:	Marital Date:				
Is the Patient under any type of Treatment?												
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Secondary J20.9 Acute bronchitis, 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? Yes No O Yes No Date of accident or beginning of illness:	Туре		Code		Diagnosis							
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 O Yes No Date of accident or beginning of illness:	Primary		J06.9		Acute upper respiratory infection, unspecified							
Accident or illness due to work? Injury due to road accident? Describe how the accident or work related injury/illness occur: Yes No Date of accident or beginning of illness:	Secondary		J20.9		Acute bronchitis, unspecified							
Accident or illness due to work? O Yes O No Date of accident or beginning of illness: Describe how the accident or work related injury/illness occur: O Yes O No	ACCIDENT/OC	CUPATIONAL	. Claim I	nformato	on (complete	if claim is a re	sult of accid	lent or work rela	ated illne	ss/injur	y)	
Date of accident or beginning of illness:	IAccident or illness due to work?			to road	Describe ho	Describe how the accident or work related injury/illness occur:						
	○ Yes ○ No			○ Yes ○	No							
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim	Date of accident or beginning of illness:					1						
	MEDICAL PLAI	N Itemized Or	iginal In	voices ar	nd Applicable	Prescriptions ,	/ Reports / F	Results must be e	enclosed	to consi	der claim	

CPT Code	Tr	reatment	Туре	/pe			Price
9	G	P Consultation	General (eneral Consultation			25.0000
Code	Generic		Duration Instructions				
0027-265802- 1161	(BUTAMIRA	TE DIHYDROGEN CITRATE : 0.15%	DIHYDROGEN CITRATE: 0.15% W/V SYRUP 7 Take 1Syrup 2 Time(s) p 7 Day(s) others				
0252-185801- 0391	•	DRAMINE : 25 MG) (PARACETAMO PHEDRINE : 30 MG) FILM COATED	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others			
0503-116407- 0391	(AMOXICILLIN: 1000 MG) FILM COATED TABLETS					Take 1Tablets 2 Time(s) per Day For 7 Day(s) others	
0195-123701- 0391	(CETIRIZINE	HCL : 10 MG) FILM COATED TABL	: 10 MG) FILM COATED TABLETS 5 F				
O Pharmacy:		Estmated Costs	○ La	ooratory / Radio	ology:	Estmated Costs	
Is the following required		O Surgery:	○ En	○ Endoscopy:			
		O Physiotherapy:	Oot	her Procedures	:		
			If yes	If yes please specify			

Is In-patient Required ? Length of Stay	Indicate Provider Estima						
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton						
& that the medical services shown on this form were	to release any informaton regarding my medical conditon of	and history to NEXtCARE					
medically indicated & necessary for the management of	for the purpose of determining insurance benefts. Medical management is the sole						
this case.	responsibility of doctor and the patent.						
Treating Physician Name : Enomen Goodluck							
Tel / Fax (important):							
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Date:	Patient's Signature(Parent if minor) Date: 23-Dec-2024						
	1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
Note: Claims must be submited along with supportng 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 efects 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.