

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	THAER MOHAMAD DHIMCH	Gender:	Male	Validity Between:	06/08/2024 and 30/04/2025
Card No:	61E4-892D-1E70-75BF	DOB:	7/20/1979 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1979-2713721-2	Service Date:	24-Dec-2024	Radiology:	Covered
		Patent's Tel No:	0527059299		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44589	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: Gritty sensation in both eyes. Duration: 1month There is associated tearing from both eyes and itching. It is said to be worst at night He is not hypertensive and not diabetic Smokes tobacco 1 stick per day. ROS: dry cough, pain in throat.									
Past Medical Surgical History?						☐ Yes		☐ No	
						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 : 36.8	HR : 78
			RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	H10.45	Other chronic allergic conjunctivitis			

Type	Code	Diagnosis
Secondary	J03.90	Acute tonsillitis, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	J06.0	Acute laryngopharyngitis

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

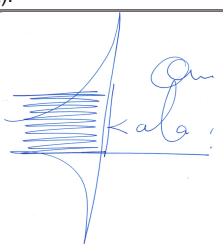
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
0085-217402-0371	(DEXAMETHASONE : 1 MG/ML) (NEOMYCIN : 3500 IU/ML) (POLYMYXIN B : 6000 UI/ML) EYE DROPS	10	Take 2Drops 3 Time(s) per Day For 10 Day(s) others
0005-119803-1171	(PREDNISOLONE : 20 MG TABLETS	7	Take 1Tablets 1Time(s) perDay For 7 Day(s) evening
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal
1111-183202-0391	(FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
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.  Patient's Signature(Parent if minor)		
Date :		
Date : 24-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 efects 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.