eASOAP FORM

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

Patent Name:	**JENNIFER DESIREE**	Gender:	**Male**	Validity Between:	**12/04/2024 and 11/04/2025**
Card No:	**2741-453F-F8C1-E898**	DOB:	**9/18/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-6810303-1**	Service Date:	**29-Dec-2024**	Radiology:	**Covered**
		Patent's Tel No:	**+971 58 684 2251**		
Policy Holder:		Threshold Limit:			
Payer Name:	**National Life And General Insurance**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45373**	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
co co fever on and off running nose productive cough ear blockage 25th dec. 2024 oe chest is congested no added sounds restless asthma taking ventoline inhalor			

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 : 200	T : 37.1	HR : 82	RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified

Type	Code	Diagnosis
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R05	Cough
Secondary	R50.9	Fever, unspecified
Secondary	H60.539	Acute contact otitis externa, unspecified ear
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R03.0	Elevated blood-pressure reading, w/o diagnosis of htn

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
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

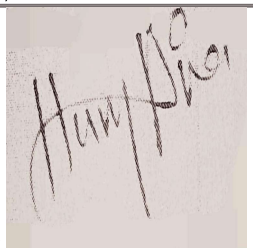
Code	Generic	Duration	Instructions
6758-533801-1561	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) DELAYED RELEASE CAPSULES	7	Take 1Capsule 2 Time(s) per Day For 7 Day(s) others
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	1	Take 10 ml 3 times in a day
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablet at night
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 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

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE

medically indicated & necessary for the management of this case.	*for the purpose of determining insurance benefits. 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 : 29-Dec-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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