

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	BHISMA UPRETI SHREE PRASAD UPRETI	Gender:	Male	Validity Between:	01/05/2024 and 30/04/2025
Card No:	25E5-6885-7795-54A0	DOB:	8/30/1990 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1990-5631323-4	Service Date:	07-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971588301095		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45472	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

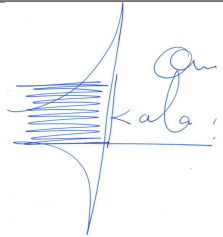
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC: Pain in throat, fever, nasal congestion and body pains, \ there is no cough duration: 3days smokes tobacco						DD	MM	YYYY
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ 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 : 140 T : 37.6 HR : 78 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			
Secondary	J30.9	Allergic rhinitis, unspecified			
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		
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
9	GP Consultation	General Consultation	25.0000		
0188-135906-2441	PULMICORT	Pharmacy	10.4800		
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300		
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		
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000		
0005-149902-1021	CLOFEN	Pharmacy	6.5000		
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000		
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000		
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		
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal		
5754-319204-0581	(EUCALYPTUS OIL : 3.4 MG) (MENTHOL : 9.3 MG) LOZENGES	5	Take 1Tablets 4 Time(s) per Day For 5 Day(s) after meal		
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	4	Take 1Tablets 2 Time(s) per Day For 4 Day(s) after meal		
0005-119805-1172	(PREDNISOLONE : 5 MG TABLETS	7	Take 2Tablets 1 Time(s) per Day For 7 Day(s) after meal		
0252-389902-1171	(LORATADINE : 5 MG (PSEUDOEPHEDRINE SULPHATE : 120 MG TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal		
☐ Pharmacy:		Estimated Costs		☐ Laboratory / Radiology:	
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 certify 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 patient.
Treating Physician Name : Enomen Goodluck	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 07-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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