

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	KHORSHED ABUL KASHAM	Gender:	Male	Validity Between:	01/05/2024 and 30/04/2025
Card No:	B54F-CD95-5E75-D29C	DOB:	2/3/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-8070592-5	Service Date:	09-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0543668997		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43782	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 productive cough running nose 5th jan. 2025 oe chest is congestion 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 : 140 T : 36.6 HR : 98 RR : 18	
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			
Secondary	K29.00	Acute gastritis without bleeding			

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

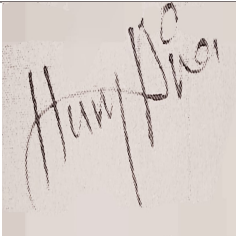
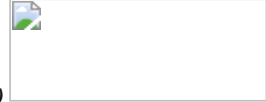
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
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☐ Yes ☐ No	☐ Yes ☐ No		
Date of accident or beginning of illness:			
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim			
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
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
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
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
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	1	Take 10 ml 3 times in a day
0207-533801-1451	(ESOMEPRazole (AS MAGNESIUM : 20 MG CAPSULES (HARD GELATIN	7	Take 1Capsule 2 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
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablet at night

☐ 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 benefits. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Humaira		
Tel / Fax (important):		

 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	
Date :	Date : 09-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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