eASOAP FORM

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

Patent Name:	**MUHAMMAD SAQUIB MUHAMMAD SIDDIQ**	Gender:	**Male**	Validity Between:	**06/06/2024 and 05/06/2025**
Card No:	**9B54-FC01-765D-1665**	DOB:	**1/2/1992 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1992-3819613-5**	Service Date:	**13-Jan-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0529821723**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Islamic Arab Insurance Co. (P.S.C.**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45064**	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 body pain dry cough 11 jan. 2025 oe chest is congested no added sounds restless smoker			

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 : 130	T : 36.8	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	R05	Cough

Type	Code	Diagnosis
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R06.2	Wheezing

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:		

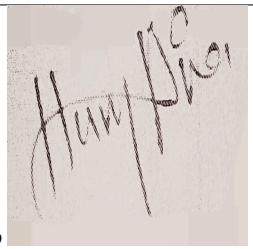
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
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
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
0278-107903-0391	(IBUPROFEN : 600 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
2118-290301-0392	(LEVOCETIRIZINE (DIHCL OR HCL) : 5 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others
0553-111903-1011	(SODIUM CHLORIDE : 0.9%) SOLUTION FOR INHALATION	6	Take 1Injection 2 Time(s) per Day For 6 Day(s) others
0553-364609-3681	(ISOTONIC SEA WATER : 27.3% / 72.7 V/V) LIQUID-SPRAY	1	Take 1Spray 1 Time(s) per Day For 1 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 medically indicated & necessary for the management of this case.	*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 benefts. 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 : 13-Jan-2025
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 fnal opinion will be given by the NEXtCARE claims doctors.