

eASOAP FORM


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

Patent Name:	HASANGA LAKSHAN RAJAPAKSHA MUNASINGHE PATHIRANAGE	Gender:	Male	Validity Between:	15/10/2024 and 14/10/2025
Card No:	3A2C-9C29-D17A-087F	DOB:	3/5/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)- MEDGULF
Natonal ID:	784-1989-9195961-4	Service Date:	16-Jan-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0565636580		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	38347	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 : sorethroat usually at night , cough with brownish sputum , 5 days no other med conditions o/e hyperemia of pharynx bronchial bretahing								
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 : Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM	Vital Signs : B/P : 105 : 18 T : 36 HR : 88 RR :
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Type	Code	Diagnosis
Primary	J21.9	Acute bronchiolitis, unspecified
Secondary	R05	Cough

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
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
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
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	6	Take 1Tablets 1Time(s) perDay For 6 Day(s) evening
0006-104201-1161	(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others
0005-134003-1161	(BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0207-368802-0391	(CEFPODOXIME (AS PROXETIL : 200 MG FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 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 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>	<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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>	
Treating Physician Name : SANDIA		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 16-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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