

eASOAP FORM

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

Patent Name:	ABDUL MAJEED MUHAMMAD RASHEED	Gender:	Male	Validity Between:	16/11/2024 and 15/11/2025
Card No:	6054-EE39-B748-7B2C	DOB:	4/1/1990 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1990-3802494-1	Service Date:	17-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0501247753		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45562	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 : COUGH WHICH IS DRY ASOCIATED WITH CHEST PAIN , BREATHING PROBLEM(DIFFICULT BREATHING) AND FEVER 2 DAYS	
NO OTHE MED CONDITIONS	
NO DRUG ALLERGY	

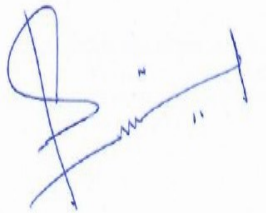
Complaint								
O/E HYPEREMIA OF PHARYNX								
CHEST CONGESTED								
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started		
						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
						DD	MM	YYYY
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:			
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 : 111 T : 36.3 HR : 81 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Primary	J02.9	Acute pharyngitis, unspecified						
Secondary	J45.991	Cough variant asthma						
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	
9	GP Consultation					General	25.0000	

CPT Code	Treatment	Type	Price
		Consultation	
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000
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
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
0006-104201-1161	(TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP	10	Take 1Tablets 3 Time(s) per Day For 10 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	1	Take 1Tablets 2Time(s) perDay For 1 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) evening

☐ 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</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</i>		

<i>this case.</i>	<i>responsibility of doctor and the patent.</i>
Treating Physician Name : SANDIA	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 17-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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