

eASOAP FORM

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

Patent Name:	BARAN YAHYA FARIS AL KURDI	Gender:	Female	Validity Between:	19/08/2024 and 31/07/2025
Card No:	60D2-3E72-E5E8-9C7A	DOB:	7/31/1997 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1997-9171841-6	Service Date:	19-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0504924969		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45582	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 : KNOWN ASTHMATIC , SORETHROAT , BODYPAIN , COUGH WITH SPUTUM	
MYALGIA FOR 4 DAYS	
O/E WHEEZING ALL OVER CHEST	

Complaint								
HYPEREMIA OF PHARYNX								
NO KNOWN DRUG ALLERGY								
treated for low vitamin d and calcium previously								
trated for severe anemia with iv iron previously								
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 : 37.2 HR : 86 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	Code	Diagnosis						
Primary	J45.991	Cough variant asthma						
Secondary	J21.9	Acute bronchiolitis, unspecified						
Secondary	R50.9	Fever, unspecified						
Secondary	M81.6	Localized osteoporosis [Lequesne]						
Secondary	D63.8	Anemia in other chronic diseases classified elsewhere						
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	Describe how the accident or work related injury/illness occur:			

		accident?	
☐ 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
82728	Ferritin	Lab	20.0000
80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), Urea nitrogen (BUN) (84520)	Lab	110.0000
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
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
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
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	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000

Code	Generic	Duration	Instructions
0085-217401-0381	(DEXAMETHASONE : 1 MG/G (NEOMYCIN : 3500 IU/G (POLYMYXIN B : 6000 IU/G EYE OINTMENT	7	Take 1Solution 2 Time(s) per Day For 7 Day(s) others
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Solution 3 Time(s) per Day For 5 Day(s) after meal
1204-395404-1171	(MONTELUKAST (AS SODIUM : 10 MG TABLETS	15	Take 1Solution 1 Time(s) per Day For 15 Day(s) evening
0009-368802-1171	(CEFPODOXIME (AS PROXETIL : 200 MG TABLETS	5	Take 1Solution 1 Time(s) per Day For 5 Day(s) after meal
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	1	Take 1Solution 1Time(s) perDay For 1 Day(s) others
0188-272103-1121	(BUDESONIDE : 160 MCG (FORMOTEROL FUMARATE : 4.5 MCG SUSPENSION FOR INHALATION	30	Take 1Tablets 2 Time(s) per Day For 30 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 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : SANDIA		
Tel / Fax (important):		
 Signature & Stamp	Patient's Signature(Parent if minor) 	

 Dr. Sandia Bhojwani General Practitioner DHA No: 65900212-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	
Date :	Date : 19-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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