

# eASOAP FORM


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

|                   |                                      |                   |                             |                          |                                       |
|-------------------|--------------------------------------|-------------------|-----------------------------|--------------------------|---------------------------------------|
| Patent Name:      | <b>ABDUL MAJEED MUHAMMAD RASHEED</b> | Gender:           | <b>Male</b>                 | Validity Between:        | <b>16/11/2024 and 15/11/2025</b>      |
| Card No:          | <b>6054-EE39-B748-7B2C</b>           | DOB:              | <b>4/1/1990 12:00:00 AM</b> | Coverage Informaton for: | <b>Out Patient</b>                    |
| Pin #:            |                                      | Identty Card:     |                             | Network:                 | <b>RN UAE (Al Ansari-AUH)-MEDGULF</b> |
| Natnol ID:        | <b>784-1990-3802494-1</b>            | Service Date:     | <b>22-Jan-2025</b>          | Radiology:               | <b>Covered</b>                        |
| Policy Holder:    |                                      | Patent's Tel No:  | <b>0501247753</b>           |                          |                                       |
| Payer Name:       | <b>ORIENT INSURANCE P.J.S.C</b>      | Threshold Limit:  |                             |                          |                                       |
|                   |                                      | Class:            | <b>Normal</b>               |                          |                                       |
| Category:         | <b>Category B</b>                    | Out-Patent :      |                             | Pharmacy:                | <b>Co-Part: 20%</b>                   |
| Gatekeeper:       | <b>No</b>                            | Patent's File No: | <b>45562</b>                | Laboratory:              | <b>Covered</b>                        |
| Referral No:      |                                      | Consultaton :     |                             |                          |                                       |
| 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 )<br><br>FEVER 2 DAYS<br><br>NO OTHE MED CONDITIONS<br><br>NO DRUG ALLERGY<br><br>O/E<br><br>HYPEREMIA OF PHARYNX<br><br>CHEST CONGESTED<br><br>LAB RESULTS : CRP MARKEDLY ELEVATED |                                   |                              |      |                 |               |                                                       |    |      |
| <b>Past Medical Surgical History?</b> <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                      |                                   |                              |      |                 |               | <b>Date of Symptoms/illness started</b><br>DD MM YYYY |    |      |
| Obs/Gyn Claims                                                                                                                                                                                                                                                                |                                   |                              |      |                 |               | <b>Date of Symptoms/illness started</b><br>DD MM YYYY |    |      |
| <input type="checkbox"/> Para                                                                                                                                                                                                                                                 | <input type="checkbox"/> Gravida: | <input type="checkbox"/> 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? <input type="radio"/> Yes <input type="radio"/> No if yes, indicate what Assessment and since when:                                                                                                                               |                                   |                              |      |                 |               |                                                       |    |      |

**OBJECTIVE / ASSESSMENT** (To be completed by Physician)

|                                                                                                                                                                                                  |             |                               |          |         |         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------------|----------|---------|---------|
| <b>Clinical Findings :</b>                                                                                                                                                                       |             | Vital Signs : B/P : 124       | T : 37.6 | HR : 96 | RR : 18 |
| <b>Assessment/Diagnosis :</b> <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Confirmed <input type="radio"/> Suspected<br><b>INDICATE DIAGNOSIS NOT SYMPTOM</b> |             |                               |          |         |         |
| <b>Type</b>                                                                                                                                                                                      | <b>Code</b> | <b>Diagnosis</b>              |          |         |         |
| Primary                                                                                                                                                                                          | J45.991     | Cough variant asthma          |          |         |         |
| Secondary                                                                                                                                                                                        | J20.9       | Acute bronchitis, unspecified |          |         |         |
| Secondary                                                                                                                                                                                        | R50.9       | Fever, unspecified            |          |         |         |

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

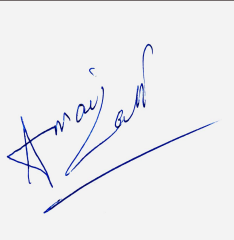
|                                                    |                                                    |                                                                 |
|----------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------|
| Accident or illness due to work?                   | Injury due to road accident?                       | Describe how the accident or work related injury/illness occur: |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> 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   |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------|
| 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 |
| 96374            | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug                                                                                                                         | Co.Pay               | 10.0000 |
| 9                | GP Consultation                                                                                                                                                                                                                                            | General Consultation | 25.0000 |
| 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 |

| Code             | Generic                                                                                                                                                                                                                                                                                                                                                                            | Duration | Instructions                                         |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------------------------------------------------|
| 0880-368802-1172 | (CEFPODOXIME (AS PROXETIL : 200 MG TABLETS                                                                                                                                                                                                                                                                                                                                         | 3        | Take 1Tablets 1 Time(s) per Day For 3 Day(s) others  |
| 2713-649101-2481 | (ZINGIBER OFFICINALE EXTRACT : 10 MG/10ML) (PIPER CUBEBA EXTRACT : 10 MG/10ML) (INULA RACEMOSA : 20 MG/10ML) (CURCUMA LONGA : 50MG/10ML) (TERMINALIA BELERICA : 20 MG/10ML) (SOLANUM INDICUM : 20 MG/10ML) (GLYCYRRHIZA GLABRA : 60 MG/10ML) (ADHATODA VASICA : 60 MG/10ML) (ALOE BARBADENSIS : 50MG/10ML) (OCIMUM SANCTUM : 100 MG/10ML) (MENTHOL : 6 MG/10ML) SYRUP (SUGAR FREE) | 10       | Take 1Tablets 3 Time(s) per Day For 10 Day(s) others |
| 6619-974001-1171 | (ELEMENTAL IRON (FERROUS BISGLYCINATE) : 24 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 2.6 MCG) (FOLIC ACID (VITAMIN B9) : 500 MCG) TABLETS                                                                                                                                                                                                                                               | 30       | Take 1Tablets 1 Time(s) per Day For 30 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 |

|                                 |                                      |                                               |                 |
|---------------------------------|--------------------------------------|-----------------------------------------------|-----------------|
| <input type="radio"/> Pharmacy: | Estimated Costs                      | <input type="radio"/> Laboratory / Radiology: | Estimated Costs |
| Is the following required       | <input type="radio"/> Surgery:       | <input type="radio"/> Endoscopy:              |                 |
|                                 | <input type="radio"/> Physiotherapy: | <input type="radio"/> Other Procedures:       |                 |
|                                 | If yes please specify                |                                               |                 |

| Is In-patient Required ? Length of Stay                                                                                                                                                                                                                                                                                                     | Indicate Provider                                                                                                                                                                                                                                                                             | Estimate Cost |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| 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 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. |               |
| Treating Physician Name : <b>DR Amaizah</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                               |               |
| Tel / Fax (important):                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                               |               |
| <br>Signature & Stamp <div data-bbox="97 562 324 772" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <b>Dr. Amaizah Ishtiaq</b><br/> General Practitioner<br/> DHA: 98486553-001<br/> CITICARE MEDICAL CENTER<br/> DUBAI - U.A.E </div> | <br>Patient's Signature(Parent if minor)                                                                                                                                                                   |               |
| Date :                                                                                                                                                                                                                                                                                                                                      | Date : 22-Jan-2025                                                                                                                                                                                                                                                                            |               |
| Note: Claims must be submitted 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.