eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the CITICARE MEDICAL CENTER LLC

	SHAMEKA SALSABIL								
Patent Name:	CHOUDHURY	Gender:	Female	Validity Between:	12/10/20	24 and 11/10	/2025		
Card No:	9545-3089-6DF4-9E25	DOB:	2/8/1994 12:00:00 AM	Coverage Informaton for:	Out Pati	ent			
Pin #:		Identty Card:		Network:	RN UAE MEDGU	(Al Ansari-A LF	UH)-		
Natonal ID:	784-1996-3747847-2	Service Date:	23-Jan-2025	Radiology:	Covered				
		Patent's Tel No:	0585884867						
Policy Holder:		Threshold Limit:							
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal						
		Out-Patent :							
Category:	Category B	Patent's File No:	45615	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						MM	YYYY		

Complaint						DD	MM	YYYY			
No Complaints Found for Selected Appointment											
Past Medical Surgical History?								Date of Symptoms/illness started			
rast ivieuitai .	ouigical History:			○ Yes	O NO		DD	MM	YYYY		
				- 40							
Obs/Gyn Clain	ns						Date of Symptoms/illness started				
☐ Para	Gravida:	AB:	LMP:	MP: Marital Status: Ma			DD	MM	YYYY		
Para	☐ Gravida:	AB:	LIVIP:	Iviantal Status:	Marital Date:						
What date did	Lthe Patient first feel sa	_l ame / similar \$	 Symptom(s)	: dd mm vvvv	l						
				if yes, indicate what Asses	ssment and since	when:					
				•							
-	ASSESSMENT(To be	сотрієтеа ву	Pnysician)		D/D - 125	Т. 2/	<u> </u>	LID . OC	RR		
Clinical Findings: Vital Signs: B/P:125 T:3					1:30	О	HR : 86	KK			
Assessment/Diagnosis : O Acute O Chronic O Confirmed O Suspected											
IN	DICATE DIAGNOSIS	NOT SYMPT	ОМ								
Туре	Code		Diagnosis								
Primary	J06.9		Acute upper respiratory infection, unspecified								
Secondary	J30.9		Allergic rhinitis, unspecified								
Secondary	R05		Cough								
Secondary	R50.9		Fever, unspecified								
Secondary	K29.0	0	Acute gastritis without bleeding								

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

https://irhamc.visionsoftwares.ae/mr_nextcare_print.aspx?appId=57349

Treating Physician Name : Humaira Tel / Fax (important):	20, 20, 10,00 1			_	innecest of the streams in				
Date of accident or beginning of illness: MEDICAL PLAN Itemized Original invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Itemized Original invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Price Price Price Seneral 0.0000 3000 TRIAXONE I.V(CEFTRIAXONE : 1 G) POWDER FOR INJECTION 0882 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for disposantic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device] 1038- 135906- PULMICORT-(BUDESONIDE : 0.5 MG/MIL) SUSPENSION FOR NEBULIZATION Pharmacy 10.4800 0195- 107704- 0681 Duration Pharmacy: Estimated Costs Outer Procedures: Outer Procedures: Outer Procedures: Five places specify Estimated Costs Pharmacy: Other Procedures: Outer Procedures: Outer Procedures: Five places specify If yes places specify Instructions	INCCIDENT OF Illness due to work?				Describe how the accide	ent or work re	elated injury/illness oc	cur:	
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim PTC Code Treatment Type Price Price Price Price Price	○ Yes ○ No			No					
CPT Code Treatment Type Price	Date of accident or beginning of illness:				1				
0.01 Follow-up consultation General Consultation Consult	MEDICAL PLAN	l Itemized Original Inv	voices and Applicable	Prescriptions	/ Reports / Results must	be enclosed to	o consider claim		
Surgery: Ceffridad Costs Ceffridad Cests Ceffridad Cests Ceffridad Cests Ceffridad Cests C	CPT Code	Treatment					Туре	Price	
107704- TRIAXONE I.V(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy 58.5000	9.01	Follow-up consulta	tion					0.0000	
94540 induction for diagnostic purposes (eg., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device) 0188-	107704-	TRIAXONE I.V(CEF	TRIAXONE : 1 G) POW	DER FOR INJEC	CTION	Pharmacy	58.5000		
13.5906-2441 PULMICORT-(BUDESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	94640	induction for diagn	ostic purposes (eg, w	ith an aerosol	generator, nebulizer, met		15.0000		
Up to 1 hour O195- 107704- 0801 Code Generic ON Perscriptions History Found Pharmacy: Estmated Costs Osurgery: Surgery: Ophysiotherapy: Other Procedures: If yes please specify Indicate Provider Insure, Employer or other Organization to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Tealing Physician Name: Humaira Tel / Fax (important): Date: Date: 23-Jan-2025	135906-	PULMICORT-(BUDE	SONIDE : 0.5 MG/ML) SUSPENSION	FOR NEBULIZATION	Pharmacy	10.4800		
Date : D	96365		n, for therapy, proph	ylaxis, or diagn	laxis, or diagnosis (specify substance or drug); initial,			40.0000	
No Prescriptions History Found Pharmacy: Estmated Costs	107704-	CEFTRIAXONE-TABL	JK IV					48.5000	
No Prescriptions History Found Pharmacy: Estmated Costs	Code	Generic		Duration	Duration Instructions				
Surgery: Estmated Costs Surgery: Estmated Costs	No Prescriptio	ns History Found							
Is the following required Surgery: Other Procedures: If yes please specify Is In-patient Required? Length of Stay I hereby certfy that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Teating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Dr. Humaira Mumtaz General Practitions DIBM IN SA15550-002 CITICARE MEDICAL CENTER LLC DIBM - U.A.E. Patient's Signature(Parent if minor) Date: 23-Jan-2025			Estmated Costs		O Laboratory / Padiole	ogv: F	stmated Costs		
Is In-patient Required? Length of Stay Indicate Provider Is In-patient Required? Length of Stay Indicate Provider Indicate Provider It hereby certfy that all information mentoned are correct that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Dt. Humaira Humtaz General Pactitioner DIA No. \$415550-002 CITICARE MEDICAL CRITERILC DIBAN-U.A.E. Patient's Signature(Parent if minor) Date: Date: 23-Jan-2025	Filalillacy.		Littrated Costs		Caboratory / Nadioit	л <u>в</u> у	Stillated costs		
Is In-patient Required ? Length of Stay Indicate Provider Indicate P			O Surgery:		○ Endoscopy:				
Is In-patient Required? Length of Stay Indicate Provider 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. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Dt. Humaira Mumtaz General Practitioner UHA NS: \$15553-002 CITICARE MEDICAL CENTER LIC UBBN-U.A.E. Patient's Signature(Parent If minor) Date: Date: 23-Jan-2025	Is the following	g required	O Physiotherapy:		Other Procedures:				
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. Treating Physician Name: Humaira Tel / Fax (important): Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No. 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date: 23-Jan-2025				If yes please specify					
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Tel / Fax (important): Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155501-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date: 23-Jan-2025	I hereby certfy & that the mea medically indic this case.	that all informaton r lical services shown o ated & necessary for	nentoned are correct on this form were	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					
Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: \$4155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date: Date: Date: 23-Jan-2025				-					
DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) Date : Date : 23-Jan-2025	Signature & Stamp Dr. Humaira Mumtaz								
Date : 23-Jan-2025	DHA NO: 54155530-002 CITICARE MEDICAL CENTER LLC Dubai - U.a.e.			Patient's Sigr					
Note: Claims must be submited along with supportng documents within 30 days from date of service	Date :								
		ust be submited alor	ng with supportng do			rvice			

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 final opinion will be given by the NEXtCARE claims doctors.