

eASOAP FORM

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

Patent Name:	DAISY LAMINTAO CABADING	Gender:	Female	Validity Between:	08/08/2024 and 07/08/2025
Card No:	5564-CECC-D97A-C120	DOB:	12/7/1983 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1983-2958437-3	Service Date:	26-Jan-2025	Radiology:	Covered
		Patent's Tel No:	971543087941		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45656	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
co fever on and off dry cough could not sleep well pain in throat nasal congestion	
2oth jan. 2025	
oe chest is congested no added sou nds	

Complaint								
restless								
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 : 130 T : 36.9 HR : 78 RR : 18				
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM								
Type	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	K29.00	Acute gastritis without bleeding						
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								

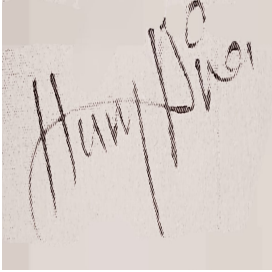
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
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
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

Code	Generic	Duration	Instructions
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML SYRUP (SUGAR FREE	1	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0669-533802-0391	(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG (PARACETAMOL : 500 MG CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablet at night

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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</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 : Humaira	
Tel / Fax (important):	
 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 26-Jan-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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