

# eASOAP FORM


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

|                   |                                |                   |                              |                          |                                       |
|-------------------|--------------------------------|-------------------|------------------------------|--------------------------|---------------------------------------|
| Patent Name:      | <b>HADI YEHYA DEBIAN</b>       | Gender:           | <b>Male</b>                  | Validity Between:        | <b>04/07/2024 and 03/07/2025</b>      |
| Card No:          | <b>A7F8-9288-4166-67E2</b>     | DOB:              | <b>9/15/2001 12:00:00 AM</b> | Coverage Informaton for: | <b>Out Patient</b>                    |
| Pin #:            |                                | Identty Card:     |                              | Network:                 | <b>RN UAE (Al Ansari-AUH)-MEDGULF</b> |
| Natonal ID:       | <b>784-2001-8237285-2</b>      | Service Date:     | <b>29-Jan-2025</b>           | Radiology:               | <b>Covered</b>                        |
| Policy Holder:    |                                | Patent's Tel No:  | <b>971582605095</b>          |                          |                                       |
|                   |                                | Threshold Limit:  |                              |                          |                                       |
| Payer Name:       | <b>UNION INSURANCE COMPANY</b> | Class:            | <b>Normal</b>                |                          |                                       |
|                   |                                | Out-Patent :      |                              |                          |                                       |
| Category:         | <b>Category B</b>              | Patent's File No: | <b>45690</b>                 | Pharmacy:                | <b>Co-Part: 20%</b>                   |
| Gatekeeper:       | <b>No</b>                      | Consultaton :     |                              | Laboratory:              | <b>Covered</b>                        |
| Referral No:      |                                |                   |                              |                          |                                       |
| Referred Service: |                                |                   |                              |                          |                                       |

**SUBJECTIVE ASSESSMENT**

|                                                                                                                                                 |                                   |                              |      |                 |                                         |    |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------|------|-----------------|-----------------------------------------|----|------|
| <b>Symptom(s) as described by the patent (Chief Complaint):</b>                                                                                 |                                   |                              |      |                 | <b>Date of Symptoms/illness started</b> |    |      |
| <b>Complaint</b>                                                                                                                                |                                   |                              |      |                 | DD                                      | MM | YYYY |
| pc : sore throat , sneezing , runny nose for 5 days                                                                                             |                                   |                              |      |                 |                                         |    |      |
| bodypain , joint pain                                                                                                                           |                                   |                              |      |                 |                                         |    |      |
| smokes tobacco                                                                                                                                  |                                   |                              |      |                 |                                         |    |      |
| o/e hyperemia of pharynx                                                                                                                        |                                   |                              |      |                 |                                         |    |      |
| chest congested                                                                                                                                 |                                   |                              |      |                 |                                         |    |      |
| <b>Past Medical Surgical History?</b>                                                                                                           |                                   |                              |      |                 | <b>Date of Symptoms/illness started</b> |    |      |
| <input type="radio"/> Yes <input type="radio"/> No                                                                                              |                                   |                              |      |                 | DD                                      | MM | YYYY |
|                                                                                                                                                 |                                   |                              |      |                 |                                         |    |      |
| <b>Obs/Gyn Claims</b>                                                                                                                           |                                   |                              |      |                 | <b>Date of Symptoms/illness started</b> |    |      |
|                                                                                                                                                 |                                   |                              |      |                 | 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 : 118 | T : 37 | HR : 86 | 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> |                         |        |         |         |

| Type      | Code  | Diagnosis                      |
|-----------|-------|--------------------------------|
| Primary   | J02.9 | Acute pharyngitis, unspecified |
| 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:          |                                                    |                                                                 |

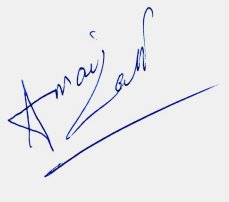
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

| CPT Code         | Treatment                                                                                                                                                                                                                                                  | Type                 | Price   |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------|
| 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 |
| 86140            | C-reactive protein;                                                                                                                                                                                                                                        | Lab                  | 15.0000 |
| 85027            | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)                                                                                                                                                                             | Lab                  | 15.0000 |
| 0005-149902-1021 | CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION                                                                                                                                                                                             | Pharmacy             | 6.5000  |
| 2190-106618-1001 | PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION                                                                                                                                                                                      | Pharmacy             | 8.4000  |
| 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 |

| Code             | Generic                                                             | Duration | Instructions                                            |
|------------------|---------------------------------------------------------------------|----------|---------------------------------------------------------|
| 1217-373201-2401 | (TOLPERISONE : 150 MG) SUGAR COATED TABLETS                         | 2        | Take 1Tablets 1 Time(s) per Day For 2 Day(s) others     |
| 0005-116702-2481 | (DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)                  | 7        | Take 1Syrup 3 Time(s) per Day For 7 Day(s) others       |
| 0005-107001-0052 | (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS                   | 5        | Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal |
| 0397-116207-0391 | (AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS | 7        | Take 1Syrup 2 Time(s) per Day For 7 Day(s) after meal   |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS                        | 7        | Take 1Syrup 1 Time(s) per Day For 7 Day(s) evening      |
| 0005-134003-1161 | (BROMHEXINE HYDROCHLORIDE : 4 MG/5ML) SYRUP                         | 7        | Take 1Syrup 3 Time(s) per Day For 7 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>I hereby certify that all informaton mentoned are correct &amp; that the medical services shown on this form were medically indicated &amp; 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 : <b>DR Amaizah</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                      |  |
| Tel / Fax (important):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                      |  |
| <div style="text-align: center;">  </div> <div> <i>Signature &amp; Stamp</i> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <b>Dr. Amaizah Ishtiaq</b><br/>         General Practitioner<br/>         DHA: 98486553-001<br/> <b>CITICARE MEDICAL CENTER</b><br/>         DUBAI - U.A.E       </div> |  | <div style="text-align: center;">  </div>                                                                                                                                                                         |  |
| Date :                                                                                                                                                                                                                                                                                                                                                                                                              |  | Date : 29-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.