

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: ANANT CHATURVEDI	Gender: Male	Validity Between: 21/03/2024 and 20/03/2025
Card No: 9ACA-FB8B-3DFF-4150	DOB: 9/15/1989 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1989-3502510-0	Service Date: 15-Feb-2025	Radiology: Covered
	Patent's Tel No: 0522443198	
Policy Holder:	Threshold Limit:	
Payer Name: ORIENT INSURANCE P.J.S.C	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 45460	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
complain of fever .runny nose and cough				
throat is congested				
chest is clear				
Past Medical Surgical History?		Date of Symptoms/illness started		
☐ Yes ☐ No		DD	MM	YYYY
Obs/Gyn Claims		Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:		DD	MM	YYYY
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:				

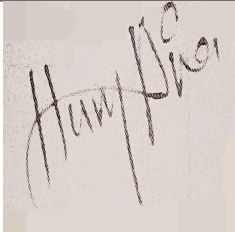
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :		Vital Signs : B/P : 126 T : 37.7 HR : 114 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	J30.9	Allergic rhinitis, unspecified			
Secondary	R05	Cough			

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
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
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
Code	Generic	Duration	Instructions
6445-533801-1561	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG DELAYED RELEASE CAPSULES	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others before meal
0139-116201-0391	(AMOXICILLIN : 250 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0878-135927-3852	(BUDESONIDE : 64 MCG/DOSE NASAL SPRAY	5	2 push two times a day
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0788-106705-1171	(CHLORPHENIRAMINE MALEATE : 2 MG (PARACETAMOL : 500 MG (PSEUDOEPHEDRINE : 30 MG TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 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 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 benefits. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : Humaira			
Tel / Fax (important):			
 Signature & Stamp		 Patient's Signature(Parent if minor)	
			
Date :		Date : 15-Feb-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service			

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