# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **MYSHA SAMIR DIGE SAMIR DIGE** | Gender: | **Female** | Validity Between: | **12/09/2024 and 11/09/2025** |
| Card No: | **53C8-4049-2FDB-F94F** | DOB: | **10/30/2022 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-2022-6769840-9** | Service Date: | **16-Feb-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0525430515** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **44125** | 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 |
| pc<br>: Intermittent fever since the past 2days.<br>Fever said to be high grade and temperature at presentation is 39.1degree.<br>Has cough and runny nose as well.<br>Also irritable cries and fussiness.<br>No change in bowel.<br>Exam: inflamed and hypertrophied tonsils | | | |

| **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 : 00 | T : 39.7 | HR : 128 | RR : 22 |
|---|---|---|---|---|

**Assessment/Diagnosis :** ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | J03.90 | Acute tonsillitis, unspecified |
| Secondary | R50.9 | Fever, unspecified |
| Secondary | R05 | Cough |
| Secondary | J06.9 | Acute upper respiratory infection, 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: |
| ○ 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 |
|---|---|---|---|
| 96365 | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour | Co.Pay | 40.0000 |
| 9 | GP Consultation | General Consultation | 25.0000 |
| 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 |
| 0195-107704-0802 | CEFTRIAXONE-TABUK IM | Pharmacy | 48.5000 |
| 2190-106618-1001 | PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION | Pharmacy | 8.4000 |
| 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 |
|---|---|---|---|
| 0005-662701-1381 | (PREDNISOLONE (SODIUM PHOSPHATE) : 20.2 MG/5 ML) SOLUTION (ORAL) | 3 | 5 ml (1 tsf ) once daily |
| 6705-602505-3801 | (HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION | 5 | Take 1Spray 1 Time(s) per Day For 5 Day(s) others |
| 0005-106604-1162 | (PARACETAMOL : 120 MG/5ML SYRUP | 1 | Take 1Syrup 1Time(s) perDay For 1 Day(s) before meal |
| 0219-142903-0852 | (CEFIXIME : 100 MG/5ML POWDER FOR SUSPENSION | 5 | 5 ml (1 tsf ) once daily |

| ○ Pharmacy: | Estmated Costs | ○ Laboratory / Radiology: | Estmated 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 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.* | *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 responsibility of doctor and the patent.* | |
| Treating Physician Name : **DR Amaizah** | | |
| Tel / Fax (important): | | |

| | |
|---|---|
| *Signature & Stamp*<br>Dr. Amaizah Ishtiaq<br>General Practitioner<br>DHA: 98486553-001<br>CITICARE MEDICAL CENTER<br>DUBAI - U.A.E | ***Patient's Signature(Parent if minor)*** |
| Date : | Date : 16-Feb-2025 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |

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