# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **ABDEL SATER ABD EL REHIM MOHAMED AHMED** | Gender: | **Male** | Validity Between: | **15/08/2024 and 14/08/2025** |
| Card No: | **7BDE-2D43-9549-E33F** | DOB: | **6/12/1971 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1971-9028061-6** | Service Date: | **09-Mar-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **505423053** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **31897** | 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** | | |
|---|---|---|---|
| | DD | MM | YYYY |
| **Complaint**<br>pc: nasal congestion , sorethroat, headache started 07/03/25 associated with low grade fever and bodyache started 09/03/25<br><br>smokes ciggarettes<br>o/e<br>bp is elevated<br>hyperemic pharynx<br>chest : clear | | | |

| **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 HR : 86 RR : 18 |
|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | J02.9 | Acute pharyngitis, unspecified |
| Secondary | J30.9 | Allergic rhinitis, unspecified |
| Secondary | R05 | Cough |
| Secondary | R09.81 | Nasal congestion |

**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 |
|---|---|---|---|
| 96372 | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | Co.Pay | 10.0000 |
| 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 |
| 0125-122107-1022 | DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION | Pharmacy | 2.3400 |
| 0005-111805-1021 | CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION | Pharmacy | 1.2000 |
| 0188-135906-2441 | PULMICORT | 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 |
| 9 | GP Consultation | General Consultation | 25.0000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0006-104201-1161 | (TRIPROLIDINE : 0.25 MG/ML) (GUAIFENESIN : 20 MG/ML) (PSEUDOEPHEDRINE : 6 MG/ML) SYRUP | 7 | 10 ml twice daily |
| 0006-106601-0393 | (PARACETAMOL : 500 MG) FILM COATED TABLETS | 2 | Take 1Tablets 2Time(s) perDay For 2 Day(s) others |
| 2733-646901-3851 | (IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML (XYLOMETAZOLINE HCL : 0.5 MG/ML NASAL SPRAY | 2 | Take 1Spray 1 Time(s) per Day For 2 Day(s) others |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG FILM COATED TABLETS | 5 | Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening |
| 0397-116206-1171 | (CLAVULANIC ACID : 125 MG (AMOXICILLIN : 875 MG TABLETS | 5 | Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal |

| ○ 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>  <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 : 09-Mar-2025 | |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | | |

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