

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	EHAB MAHMOUD HAMOUDA	Gender:	Male	Validity Between:	05/03/2025 and 04/03/2026
Card No:	E06B-88CC-4DAF-173A	DOB:	10/16/1964 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1964-7617374-3	Service Date:	29-Mar-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971507343592		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	39887	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started		
Complaint cough with green sputum flu nasal congesion bodyache headache weakness lips are dry and looking dehydrated o/e hyperemia severe chest congesion				DD	MM	YYYY
Past Medical Surgical History?			☐ Yes	☐ No	Date of Symptoms/illness started	
					DD	MM
Obs/Gyn Claims					Date of Symptoms/illness started	
					DD	MM
☐ 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 : 142 : 0	T : 36.6	HR : 84	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM		
Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	R07.0	Pain in throat
Secondary	M54.5	Low back pain
Secondary	R05	Cough
Secondary	R06.2	Wheezing

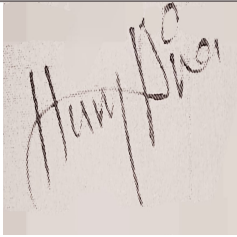
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim			
CPT Code	Treatment	Type	Price
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
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
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
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
6823-112202-3851	(AZELASTINE HCL : 1 MG/ML) NASAL SPRAY	5	Take 1Spray 1 Time(s) per Day For 5 Day(s) others
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0320-148701-1171	(LORATADINE : 10 MG) TABLETS	1	Take 1Tablets 2 Time(s) per Day For 1 Day(s) others
0207-169703-1161	(AMMONIUM CHLORIDE : N/A) (DIPHENHYDRAMINE : N/A) SYRUP	5	Take 10ML 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 : 29-Mar-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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