

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 (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1964-7617374-3	Service Date:	01-Apr-2025	Radiology:	Covered
		Patent's Tel No:	971507343592		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	39887	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

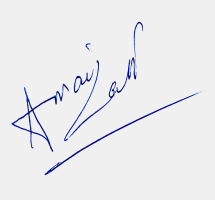
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC : SORE THROAT , COUGH , SNEEZING , HEDACHE , BODY ACHE AND LOW GRADE FEVER STARTD 30/03/25 O/E : LOOOK LETHARGIC , DEHYDRTAED HYPEREMIC PHARYNX TONSILS ARE SWOLLEN WITH PUS POINTS CHEST WHEEZING								
Past Medical Surgical History?						☐ Yes		☐ No
						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 : 135 T : 36.5 HR : 78 RR : 0		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J03.91	Acute recurrent tonsillitis, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	R52	Pain, unspecified			
Secondary	J35.1	Hypertrophy of tonsils			

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
9.01	Follow-up consultation	General Consultation	0.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
Code	Generic	Duration	Instructions
0219-533801-0392	(ESOMEPRAZOLE (AS MAGNESIUM : 20 MG FILM COATED TABLETS	5	Take 1Spray 1 Time(s) per Day For 5 Day(s) morning empty stomach
6705-602505-3801	(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	3	Take 1Spray 2 Time(s) per Day For 3 Day(s) after meal
0027-149906-1171	(DICLOFENAC SODIUM : 25 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
☐ 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>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>		
<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 : DR Amaizah		
Tel / Fax (important):		
 Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E		
Date :		Date : 01-Apr-2025
Note: Claims must be submitted along with supportng documents within 30 days from date of service		

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