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:	**03-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 came for follow up for repeating the medication			

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 : T : HR : RR :

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

Type	Code	Diagnosis
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:		

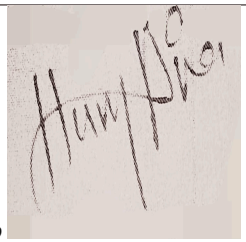
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9.01	Follow-up consultation	General Consultation	0.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
No Prescriptions History Found			

◯ 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 : **Humaira**		
Tel / Fax (important):		

Signature & Stamp  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 03-Apr-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	