

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MARICEL BONIFACIO DAVIS	Gender:	Female	Validity Between:	24/05/2024 and 23/05/2025
Card No:	E99D-2384-A093-05FE	DOB:	1/1/1986 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1986-6381826-2	Service Date:	13-Apr-2025	Radiology:	Covered
		Patent's Tel No:	0554217931		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43649	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 , body pain , sneezing , started 10/04/25				
o/e : look pale				
hyperemic pharynx				
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 : 120 T : 36.8 HR : 74 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected		
INDICATE DIAGNOSIS NOT SYMPTOM		
Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	R52	Pain, unspecified
Secondary	E86.0	Dehydration
Secondary	R03.1	Nonspecific low blood-pressure reading
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
9	GP Consultation	General Consultation	25.0000

CPT Code	Treatment	Type	Price
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300
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
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
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000

Code	Generic	Duration	Instructions
1393-135904-2441	(BUDESONIDE : 0.5 MG/2ML) SUSPENSION FOR NEBULIZATION	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
6705-602505-3801	(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	5	Take 1Tablets 1 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>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):		
 Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E		 Patient's Signature(Parent if minor)
Date :		Date : 13-Apr-2025

Note: Claims must be submitted along with supporting documents within 30 days from date of service

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