

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	VIOLY PAGAL 8032047-5	Gender:	Female	Validity Between:	14/09/2024 and 13/09/2025
Card No:	8FA4-D282-210B-5497	DOB:	6/17/1977 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1977-8032047-5	Service Date:	21-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0508047363		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	46559	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
patient came with runnynose sneezing high grade fever and mild sore throat and body ache for one day								
oe throat is mild hyperemic								
chest is clear								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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:								

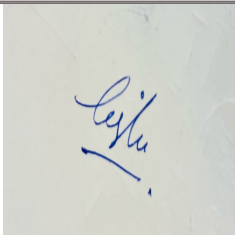
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :				Vital Signs : B/P : 130 T : 37.7 HR : 84 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J02.9	Acute pharyngitis, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	R05	Cough			
Secondary	J30.9	Allergic rhinitis, unspecified			
Secondary	R52	Pain, unspecified			
Secondary	R06.7	Sneezing			

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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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		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000		
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000		
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400		
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000		
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		
Code	Generic	Duration	Instructions		
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	5	Take 1Syrup 2 Time(s) per Day For 5 Day(s) others		
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others		
0097-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others		
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 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 benefets. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : AISHA					
Tel / Fax (important):					
 Signature & Stamp		 Patient's Signature(Parent if minor)			
Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E					

Date :	Date : 21-Apr-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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