

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: AHMED NABIL	Gender: Male	Validity Between: 23/01/2025 and 22/01/2026
Card No: 2A01-8E13-D29F-8EB1	DOB: 8/6/1988 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1988-0949495-2	Service Date: 03-May-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0567994771	
Payer Name: AL SAGAR NATIONAL INSURANCE COMPANY	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent :	
Gatekeeper: No	Patent's File No: 42866	Pharmacy: Co-Part: 20%
Referral No:	Consultaton :	Laboratory: Covered
Referred Service:		

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):		Date of Symptoms/illness started		
Complaint		DD	MM	YYYY
PT CAME WITH PRODUCTIVE COUGH FOR THE LAST ONE WEEK				
IT STARTED SUDDENLY .PATIENT ALSO COMPLAIN OF THROAT PAIN ALONG WITH DIFFICULTY IN BREATHING .				
ON EXAM.THROAT IS MILD HYPEREMIC				
CHEST IS CONGESTED				
WHEEZING SOUND MAINLY LEFT SIDE				
on investigation there is deranged CBC				
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:				

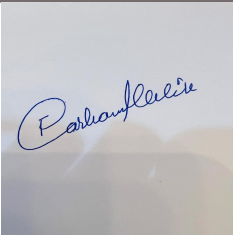
OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :	Vital Signs : B/P : 120 T : 36.6 HR : 72 RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected	
INDICATE DIAGNOSIS NOT SYMPTOM	
Type	Code
Diagnosis	
No Diagnosis Found for Selected Appointment	

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:
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☐ 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
Code	Generic	Duration	Instructions
0097-395404-0391	(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	5	Take 10 Unit(s), 3 Time(s) per Day For 5 Day(s)
☐ 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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Dr.Farhan Iyas		
Tel / Fax (important):		
 Signature & Stamp Dr .Frahna Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E	Patient's Signature(Parent if minor)	
Date :		Date : 03-May-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.