# eASOAP FORM

**ADMINISTRATIVE** The member is allowed for **Out Patient** at the **CITICARE MEDICAL CENTER LLC**

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **NOUHA EP ABU SEIFEIN** | Gender: | **Female** | Validity Between: | **28/01/2025 and 27/01/2026** |
| Card No: | **8D2E-7CF2-E07F-82AA** | DOB: | **8/22/2001 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-2001-8085369-7** | Service Date: | **04-May-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0528702099** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **45670** | 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 |
| PT CAME WITH HIGH GRADE FEVER ALONG WITH SEVER THROAT PAIN AND LEFT EAR PAIN .<br>OE THROAT IS HYPEREMIC<br>EAR IS BLOCKK WITH WAX | | | |

| **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 : 118 T : 37.9 HR : 108 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 | R52 | Pain, unspecified |
| Secondary | R03.1 | Nonspecific low blood-pressure reading |
| Secondary | H61.20 | Impacted cerumen, unspecified ear |

| 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: | | |

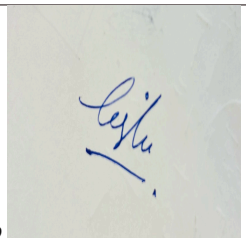
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

| CPT Code | Treatment | Type | Price |
|---|---|---|---|
| 86141 | C-reactive protein; high sensitivity (hsCRP) | Lab | 30.0000 |
| 2190-106618-1001 | PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION | Pharmacy | 8.4000 |
| 0125-122107-1022 | DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION | Pharmacy | 2.3400 |
| 0005-149902-1021 | CLOFEN | Pharmacy | 6.5000 |
| 0195-107704-0801 | CEFTRIAXONE-TABUK IV | Pharmacy | 48.5000 |
| 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 |
| 0102-100104-1001 | SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION | Pharmacy | 4.5000 |
| 96360 | Intravenous infusion, hydration; initial, 31 minutes to 1 hour | Co.Pay | 25.0000 |
| 9 | GP Consultation | General Consultation | 25.0000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0003-281701-0241 | (BENZOCAINE : 1.4%) (TYROTHRICIN : 0.05%) (ANTIPYRINE : 5%) (HEXYLRESORCINOL : 0.10%) EAR DROPS | 5 | Take 1 2Time(s) perDay For 5 Day(s) others |
| 0005-119805-1172 | (PREDNISOLONE : 5 MG) TABLETS | 5 | Take 1Tablets 1 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 |
| 0097-127405-0392 | (AZITHROMYCIN : 500 MG) FILM COATED TABLETS | 5 | Take 1Tablets 2 Time(s) per Day For 5 Day(s) others |

| ○ 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 : **AISHA** | | |
| Tel / Fax (important): | | |

| | |
|---|---|
| *Signature & Stamp*<br>  <br>Dr. Aisha Umer<br>Physician- General Practitioner<br>DHA- 40131439-002<br>CITICARE MEDICAL CENTER<br>DUBAI - U.A.E | ***Patient's Signature(Parent if minor)***  |
| Date : | Date : 04-May-2025 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |