eASOAP FORM

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

Patent Name:	**JUGRAJ BOTHRA**	Gender:	**Male**	Validity Between:	**27/12/2024 and 26/12/2025**
Card No:	**37C8-2ECB-680E-AF04**	DOB:	**1/15/1938 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1938-5462724-2**	Service Date:	**22-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0561211405**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42962**	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**		
	DD	MM	YYYY
Complaint pc : productive cough hopc : pt came with the complain of productive cough started 15 days back o/e chest is mild congested no fever allergies : none pmh : haemoglobin low			

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 : 130	T : 36.8	HR : 82	RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J45.991	Cough variant asthma
Secondary	R06.2	Wheezing
Secondary	D64.9	Anemia, unspecified
Secondary	R68.2	Dry mouth, unspecified

Type	Code	Diagnosis
Secondary	R50.9	Fever, unspecified
Secondary	R52	Pain, unspecified
Secondary	E87.1	Hypo-osmolality and hyponatremia

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

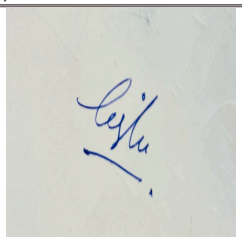
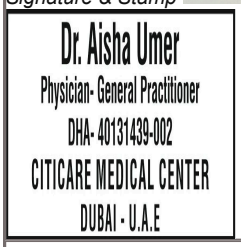
CPT Code	Treatment	Type	Price
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
9	GP Consultation	General Consultation	25.0000
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
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800

Code	Generic	Duration	Instructions
0270-134501-1431	(CETALKONIUM CHLORIDE : N/A) (CHOLINE SALICYLATE : 8.7%) BUCCAL GEL	5	Take 1Gel 1 Time(s) per Day For 5 Day(s) others
6665-944701-1171	((6S)-5-METHYLTETRAHYDROFOLIC ACID AS QUATRECFOLIC : 0.741 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	5	Take 1Solution 2 Time(s) per Day For 5 Day(s) others
0015-101502-0271	(ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0837-277601-1161	(OXOMEMAZINE : 0.33 MG/ML) SYRUP	7	Take 1Syrup 2 Time(s) per Day For 7 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  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 22-Jul-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	