## **eASOAP FORM**



**ADMINISTRATIVE** 

The member is allowed for **Out Patient** 

at the CITICARE MEDICAL CENTER LLC

Patent Name: SAMAH NAJI HMA MOHAMMAD			'	Gender:	Female		Validity Between:	01/06/2	01/06/2025 and 31/05/2026			
Card No:	51A4-1A97-EDFB-07F6		<b>7F6</b> [	оов:	8/29/1992 AM	2 12:00:00	Coverage Informato for:	Out Pa	Out Patient			
Pin #:			I	dentty Card:			Network:		RN UAE (Al Ansari-AUH)- MEDGULF			
Natonal ID:	Natonal ID: <b>784-1992-8252950-4</b>		S	ervice Date:	26-Jul-20	25	Radiology:	Covere	d			
			F	atent's Tel N	lo: <b>0509178</b> 5	571						
Policy Holder:				hreshold imit:								
Payer Name:	ORIENT INSURANCE P.J.S.C			Class:	Normal							
			(	Out-Patent :								
Category:	Category E	3		Patent's File	47474		Pharmacy:	Co-Par	Co-Part: 20%			
Gatekeeper:	No		-	Consultaton :	:	Laboratory:		Covere	Covered			
Referral No:												
Referred												
Service:												
SUBJECTIVE ASS	SESSMENT											
Symptom(s) as	described by	y the pate	nt (Chie	f Complaint)	:			Date of	Symptom	s/illness st	arted	
Complaint								DD	MM	YYYY		
patient came	with shortne	ss of brea	ıth									
					_			Date of	Date of Symptoms/illness started			
Past Medical Su	ırgical Histor	ry?			○Yes		○No	DD	MM	YYYY		
Obs/Gyn Claims	;								7	ns/illness st	tarted	
				1			L	DD	MM	YYYY		
Para	☐ Gravida:		AB:	LMP:	Marital Statu	IS:	Marital Date:	_				
What date did th	e Patient first	feel same	/ similar	Symptom(s)	: dd mm vvvv	v	l					
						-	ssment and since wh	en:				
					700)			-				
OBJECTIVE / AS		(To be con	npieted b	y Physician)		V(t-1 C:	D/D : 125	T . 2C 0	LID .	100	DD	
Cillical Filluling	ъ.					Vital Signs : : 94	B/P: 125	Т : 36.8	HR:	100	RR	
Assessment/Di	agnosis : ICATE DIAGN	O Acute		Chronic TOM	O Confirme	ed OSusp	ected					
Туре	Co	ode	D	iagnosis								
Primary			Sł	Shortness of breath								
Secondary RO		0.00	Ta	Tachycardia, unspecified								
Secondary E86.0		D	Dehydration									
Secondary R05		C	Cough									
Secondary												
Secondary	ondary J45.21 Mild intermittent asthma with (acute) exacerbation											
ACCIDENT/OCC	UPATIONAL	Claim Info	ormaton	(complete i	if claim is a re	esult of accid	ent or work related	illness/iniur	v)			
Assident or illness due to work?				Injury due accident?		road Describe how the accident or work related illness/injury)						
○ Yes ○ No				○ Yes ○ No								
Date of accider	t or beginnin	ng of illnes	SS:	1	-	1						
				Applicable I	Prescriptions	/ Reports / R	esults must be enclo	sed to consi	der claim			

or Initial substance/drug 1073-1 107704- CEFTRIAXONE-TABUK IV-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy 48.5000 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 1022- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 1022- DEXAMETHASONE SODIUM PHOSPHATE 1022- Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes; (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device.  94640 Intermittent positive pressure breathing (IPPB) device.  VNTOLIN NEBULES (SALBUTAMOL: 5 Mg/2.5ML) NEBULIZING SOLUTION Pharmacy 1.5300 1088-135906- PULIMICORT-(BUDESONIDE: 0.5 Mg/ML) SUSPENSION FOR NEBULIZATION Pharmacy: Pharmacy 1.04800  1089-135906- REPUBLIZATION Pharmacy: Strmated Costs  Street following required Strmated Costs  Surgery: Detailed Procedures: Physioten Procedures: Physioten Required 2 Length of Stay 1.04800  1 Surgery: Detailed Procedures: Physioten Required 2 Length of Stay 1.04800  1 Indicate Provider Strmated Costs  Surgery: Detailed Procedures: Physioten Required 2 Length of Stay 1.04800  2 In patient Required 2 Length of Stay 1.04800  3 Indicate Provider Required 2 Length of Stay 1.04800  3 Indicate Provider Required 2 Length of Stay 1.04800  4 President Required 8 Recessory for the management of Physiolian Name: AISHA  6 If Fax (important):  Patient's Signature/Parent If minor)  Pharmacy 48.5000  CO.Pay 10.0000  CO.Pay 10.0000  CO.Pay 10.0000  Pharmacy 2.3400  Pharmacy 2.3400  Pharmacy 3.3400  P	CPT Code	Trea	tment							Туре	Price
107704- CEFTRIAXONE-TABUK IV-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy 48.5000   96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular   1025-   102107- DEXAMETHASONE SODIUM PHOSPHATE   Pharmacy 2.3400   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 postive pressure breating (IPP9) device.  94640 VENTOLIN NEBULES-(SALBUTAMOL: 5 MG/2.5ML) NEBULIZING SOLUTION Pharmacy 1.5300   1038-135906- PULMICORT-(BUDESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-135906- (IQUESONIDE: 0.5 MG/ML) SUSPENSION FOR NEBULIZATION Pharmacy 1.04800   1040-1389-1399-1399-1399-1399-1399-1399-1399	96374								Co.Pay	10.0000	
10.000. 10.125-10.22107-10.222  DEXAMETHASONE SODIUM PHOSPHATE  Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g. with an aerosol generator, nebulizer, metered dose inhaler or co.Pay 15.0000 (10.000-10.0000-10.00000-10.00000-10.00000000	107704-	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION							Pharmacy	48.5000	
22400-   DEXAMETHASONE SODIUM PHOSPHATE   Pharmacy   2.3400	96372										10.0000
194640   induction for diagnostic purposes (eg., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)	122107-	DEX	DEXAMETHASONE SODIUM PHOSPHATE							Pharmacy	2.3400
402803- VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION  10188-135906- 2441  Code	94640	induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or							Co.Pay	15.0000	
Duration   Pharmacy   10.4800	402803-	VEN.	VENTOLIN NEBULES-(SALBUTAMOL : 5 MG/2.5ML) NEBULIZING SOLUTION							Pharmacy	1.5300
Take 1 Solution 2 Time(s) per Day For 7 Day(s) others   Take 1 Solution 2 Time(s) per Day For 7 Day(s) others	135906-	PULI	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION							Pharmacy	10.4800
Take 1 Solution 2 Time(s) per Day For 7 Day(s) others   Take 1 Solution 2 Time(s) per Day For 7 Day(s) others	Codo		Comonio				Dunation	Instructions			
Surgery: Other Procedures: If yes please specify  Sin-patient Required ? Length of Stay I hereby certfy that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Freating Physician Name : AISHA  Tel / Fax (important):  Signature & Stamp  Dt. Aisha Uner Physical Stamp  Dt. Aisha Uner Physical Genetal Paditions District Center D	0188-135906	0188-135906- (BUDESONIDE : 0.5 MG/ML) SUSPEN					7 Take 1Solution 2 Time(s) p			per Day For 7 Day(s)	
Indicate Provider  Se In-patient Required ? Length of Stay  Indicate Provider  Indicate P	O Pharmacy:	O Pharmacy: Estmated Costs				O Labo	Laboratory / Radiology: Estmated C			osts	
If yes please specify  If yes please specify  If yes please specify  Indicate Provider  Indicate Provider, Insurer, Employer or other Organizaton to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.  Indicate Provider  Ind	Surge			O Surgery:	Surgery:			doscopy:			
Indicate Provider  Indicate Prov	Is the following required		O Physiotherapy:	Othe	Other Procedures:						
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.  Treating Physician Name : AISHA  Tel / Fax (important):  Signature & Stamp  Dr. Alsha Uner Physician Geneal Practitions  DHA 4031439-002  CITICARE NEDICAL CENTER  DUBAI-U.A.E  Patient's Signature(Parent if minor)  Date : 26-Jul-2025					If yes please specify						
to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.    Signature & Stamp	Is In-patient Red	quired '	? Length of Stay	/		Indicate	Provider			Estimat	e Cost
Signature & Stamp  Dr. Aisha Umer Physician- General Practitioner DHA-40131439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E  Patient's Signature(Parent if minor)  Date: Date:	& that the medical services shown on this form were medically indicated & necessary for the management of this case.				to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole						
Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI- U.A.E  Patient's Signature(Parent if minor)  Date: Dat											
Date : Date : 26-Jul-2025	Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER			Patient's Sign	ature(Pare	ent if minor)					
Note: Claims must be submited along with supportng documents within 30 days from date of service	Date :	1 10			1		ant ii iiiiiilor) L				
		ust be	submited alor	ng with supportng doc			from date o	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 efects 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.