eASOAP FORM

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

Patent Name:	**AMNA ALI MOHAMMAD ALI BILAL**	Gender:	**Female**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**1D35-B22E-9CAE-E388**	DOB:	**10/10/2010 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2010-7516913-2**	Service Date:	**15-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0508700446**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39917**	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
tcame with sore throat flue like symptoms , cough and high grade fever for two days . o/e throat is hyperemic chest is congested bilateral wheeze			

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 : 109	T : 36.4	HR : 94	RR : 24

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	R06.2	Wheezing
Secondary	R09.81	Nasal congestion
Secondary	R21	Rash and other nonspecific skin eruption

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

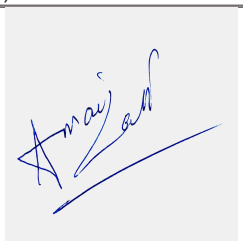
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9	Consultation GP	General Consultation	60.0000
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler orintermittent positive pressure breathing (IPPB) device	Co.Pay	52.0000
86140	C-reactive protein;	Lab	25.2000
85027	Blood count; complete (CBC),automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	52.0000

Code	Generic	Duration	Instructions
2733-646901-3851	(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	3	nasal spray
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	5	Take 15ML 2 Time(s) per Day For 5 Day(s) after meal
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0397-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal

○ 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 : **DR Amaizah**		
Tel / Fax (important):		
Signature & Stamp  Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 15-Aug-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		