eASOAP FORM

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

Patent Name:	**HYDERALI ALLABAX DUKANDAR**	Gender:	**Male**	Validity Between:	**24/03/2025 and 31/12/2025**
Card No:	**F221-3702-C669-6446**	DOB:	**12/24/1989 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1989-2705862-2**	Service Date:	**23-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0552906380**		
Policy Holder:		Threshold Limit:			
Payer Name:	**NATIONAL GENERAL INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**30737**	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 : SEVERE SORE THROAT , HEADACHE , NASAL CONGESTION , AMD COUGH WHICH IS DRY AND LOW GRADE FEVER STARTED 22/08/25 O/E : LOOK PALE AND LETHARGIC HYPEREMIC PHARYNX COBBLESTONE APPERANCE DIFFICULTY SWALLOWING FOOD REDUCED ORAL INATKE FOR LAST 3 DAYS CAUSING LOW BLOOD PRESSUREE NEED IV RINGER NASL CONGESTION WHEEZING			

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 : T : HR : RR :

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R05	Cough
Secondary	R06.2	Wheezing
Secondary	R50.9	Fever, unspecified
Secondary	E86.0	Dehydration

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	GP Consultation	General Consultation	25.0000
82785	Gammaglobulin (immunoglobulin); IgE	Lab	20.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
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
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
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	7.5000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	15.5000

Code	Generic	Duration	Instructions
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	3	Take 1sachet 1Time(s) perDay For 3 Day(s) after meal
2733-646901-3851	(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	3	Take 2Spray 1 Time(s) per Day For 3 Day(s) after meal
8132-107203-1171	(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	5	Take 1Tablets 1 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 : 23-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	