eASOAP FORM

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

Patent Name:	**QASSIM DARWISH KHAMIS SHAYIB**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**A788-67E4-643B-73D5**	DOB:	**8/12/1979 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1979-3725921-2**	Service Date:	**25-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**971552055733**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**45704**	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
PC : FEVER , THROAT PAIN PAIN AND RUNNY NOSE HOPC : PT CAME WITH THE COMPLAIN OF THROAT PAIN AND FEVER ALOBG WITH RUNNY NOSE STARTED TWO DAYS BACK O/E THROAT IS HYPEREMIC CHEST ISCONGESTED HE HAS HIGH BLOOD PRESSURE AS WELL ALLERGIES : NONE			

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 : 160 T : 37.7 HR : 80 RR : 16

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	R06.2	Wheezing

Type	Code	Diagnosis
Secondary	J30.89	Other allergic rhinitis
Secondary	R07.0	Pain in throat

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:		

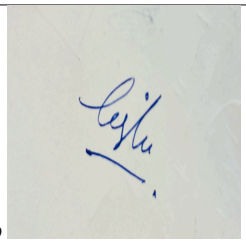
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	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
9	GP Consultation	General Consultation	25.0000
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

Code	Generic	Duration	Instructions
0846-105109-0271	(HERBS : 65 MG) EFFERVESCENT TABLETS	5	Take 1Syrup 2 Time(s) per Day For 5 Day(s) others
0070-148901-1171	(LORATADINE : 5 MG) (PSEUDOEPHEDRINE : 120 MG) TABLETS	5	Take 1Tablets 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
0009-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	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  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 
Date :	Date : 25-Aug-2025
Note: Claims must be submited along with supportng documents within 30 days from date of service	