

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	YOSSRA BEN SLIMENE	Gender:	Female	Validity Between:	26/02/2024 and 13/06/2024
Card No:	720C-7F43-7BAD-049B	DOB:	5/3/1987 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1987-1080708-6	Service Date:	26-Sep-2024	Radiology:	Covered
		Patent's Tel No:	971561771000		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41330	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
co fever on and off running nose productive cough bad order from mouth 21st sep. 2024						
oe						
tonsills enlarge						
chest is congested no added sounds						
restless						
smoker						
Past Medical Surgical History?				Date of Symptoms/illness started		
☐ Yes ☐ No				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 : 99 : 18	T : 36.7	HR : 75	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R05	Cough
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R50.9	Fever, unspecified

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:		

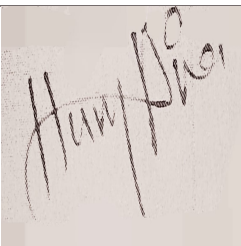
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0801	CEFTRIAZONE-TABUK IV-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
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

Code	Generic	Duration	Instructions
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	1	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	6	Take 1Tablets 2 Time(s) per Day For 6 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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>		
<i>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Humaira		
Tel / Fax (important):		

 <i>Signature & Stamp</i> Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 26-Sep-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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