

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	BASHARAT ALI MUHAMMAD TARIQ	Gender:	Male	Validity Between:	16/11/2024 and 15/11/2025
Card No:	A1AB-496E-6A65-0192	DOB:	3/6/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-6869092-9	Service Date:	12-Feb-2025	Radiology:	Covered
		Patent's Tel No:	0509384669		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45815	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 ; sore throat, bodypain , blocked nose , cough with sputum for 1 week							
no other med conditions							
bp is elevated							
family hx of HtN							
O/E : LOOK LETARGIC							
HYPEREMIA OF P[HARYNX							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					DD	MM	YYYY
Obs/Gyn Claims					Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:					DD	MM	YYYY
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 : 150	T : 36.4	HR : 108	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	J45.991	Cough variant asthma
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	E78.2	Mixed hyperlipidemia
Secondary	I10	Essential (primary) hypertension

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:		

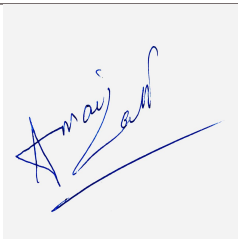
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000

Code	Generic	Duration	Instructions
0207-379202-1171	(AMLODIPINE (AS BESYLATE : 10 MG TABLETS	1	Take 1Tablets 1Time(s) perDay For 1 Day(s) others
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	7	Take 1Syrup 2 Time(s) per Day For 7 Day(s) others
6705-602506-3851	(HYDROXYPROPYLMETHYLCELLULOSE : 90 MG/ 30ML) NASAL SPRAY	4	Take 1Spray 1 Time(s) per Day For 4 Day(s) others
2713-644001-0581	(LEVOMENTHOL : 7 MG) (EMBLICA OFFICINALIS : 10 MG) (GLYCYRRHIZA GLABRA : 15 MG) (ZINGIBER OFFICINALE : 10 MG) LOZENGES	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0880-368802-1172	(CEFPODOXIME (AS PROXETIL : 200 MG TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 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 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 benefets. 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 : 12-Feb-2025

Note: Claims must be submitted along with supporting documents within 30 days from date of service

Disclaimer: NEXtCARE ASOAP form is used for claim creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.