

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: SYARDI RUSLAN	Gender: Male	Validity Between: 25/11/2024 and 24/11/2025
Card No: 7144-EBEE-EF3B-3F69	DOB: 9/29/1959 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1959-7522549-1	Service Date: 04-Mar-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0585598803	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent :	
Gatekeeper: No	Patent's File No: 41622	Pharmacy: Co-Part: 20%
Referral No:	Consultaton :	Laboratory: Covered
Referred Service:		

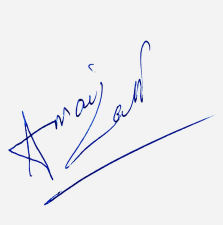
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):		Date of Symptoms/illness started		
Complaint		DD	MM	YYYY
PC : SORETHROAT , ASSOCIATED WITH EAR ACHE , AND DIFFICULY IN SWALLOWING ASSOCIATED WITH LOW GARDE FEVER				
O/E : HYPEREMIC PHARYNX				
CHEST : CONGSETED				
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 : 157 T : 36.8 HR : 85 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J03.90	Acute tonsillitis, unspecified			
Secondary	J02.9	Acute pharyngitis, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	R52	Pain, 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		
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	3.1000		
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		
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000		
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
Code	Generic	Duration	Instructions		
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal		
0005-107101-0051	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 325 MG) CAPLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal		
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	5	Take 1Tablets 2Time(s) perDay For 5 Day(s) others		
6705-602505-3801	(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	4	Take 1Spray 2 Time(s) per Day For 4 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 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 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 benefits. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : DR Amaizah					
Tel / Fax (important):					
 Signature & Stamp		 Patient's Signature(Parent if minor)			
 Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E					
Date :		Date : 04-Mar-2025			
Note: Claims must be submitted along with supporting documents within 30 days from date of service					

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