

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AMIR HAMZA AMIR	Gender:	Male	Validity Between:	19/05/2024 and 18/05/2025
Card No:	4A56-9A04-2A54-162A	DOB:	2/12/2000 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2000-6073858-8	Service Date:	18-Mar-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0522214776		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45485	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

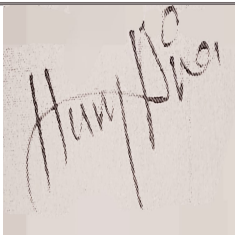
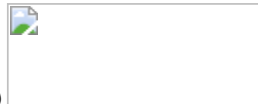
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started		
Complaint				DD	MM	YYYY
pain in right side of chest near armpit. since last night. sore throat runny nose nasal congestion o/e hyperemia chest is clear						
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 : 130 T : 36.8 HR : 86 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	M62.838	Other muscle spasm	
Secondary	R52	Pain, unspecified	
Secondary	J02.9	Acute pharyngitis, 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
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
Code	Generic	Duration	Instructions
0031-149904-1171	(DICLOFENAC SODIUM : 50 MG TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
4884-622202-1171	(SERRAPEPTASE : 10 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0097-127402-0391	(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0320-148701-1171	(LORATADINE : 10 MG) TABLETS	5	Take 1Tablets 2 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 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 benefets. Medical management is the sole responsibility of doctor and the patent.		
Treating Physician Name : Humaira		
Tel / Fax (important):		
Signature & Stamp  Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor) 		
Date :		
Date : 18-Mar-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 creaton 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 fnal opinion will be given by the NEXtCARE claims doctors.