

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:	22-Mar-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0509384669		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45815	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started						
Complaint PC : SORE THROAT , BODYPAIN , FEVER STARTED 20/03/25 O/E : LOOK LETHARGIC DEHYDRATED SWOLLEN TONSILLS WITH PUS POINTS HYPEREMIC PHARYNX CHEST CONGESTED						DD	MM	YYYY				
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 : 120 T : 37.1 HR : 80 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J03.90	Acute tonsillitis, unspecified					
Secondary	R05	Cough					
Secondary	R06.2	Wheezing					

Type	Code	Diagnosis
Secondary	R50.9	Fever, 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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
9	GP Consultation	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000

Code	Generic	Duration	Instructions
0397-116207-0391	(AMOXICILLIN : 500 MG (CLAVULANIC ACID : 125 MG FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
6705-602505-3801	(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	3	Take 1Spray 2 Time(s) per Day For 3 Day(s) after meal
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0252-389902-1171	(LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS	5	Take 1 Unit(s), 1 Time(s) per Day For 5 Day(s)

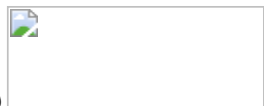
☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
		If yes please specify	

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 benefsts. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		

Amaizah

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 : 22-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 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.