eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out Patient** at the **CITICARE MEDICAL CE**

Patent Name:	**RENU NEPALI**	Gender:	**Female**	Validity Between:	**25/07/2024 and 2**
Card No:	**2252-FDA8-283B-2F81**	DOB:	**9/5/1988 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansa MEDGULF**
Natonal ID:	**784-1988-9284107-7**	Service Date:	**23-Mar-2025**	Radiology:	**Covered**
		Patent's Tel No:	**058 569 3550**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**38445**	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 Sympton**	
Complaint	DD	MM
pc : pain in left arm and shoulder started 22/03/25 elevtaed blood pressure o/e : look lethargic and pale tender shoulder joint		

Past Medical Surgical History?	○ Yes	○ No	**Date of Sympton**	
			DD	MM

Obs/Gyn Claims						**Date of Sympton**	
						DD	MM
☐ 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 : 150 T : 36.8 HR : 22

Assessment/Diagnosis : ○ Acute ○ Chronic ○ Confirmed ○ Suspected

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R03.0	Elevated blood-pressure reading, w/o diagnosis of htn
Secondary	R52	Pain, unspecified
Secondary	M79.603	Pain in arm, unspecified
Secondary	E78.5	Hyperlipidemia, 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/illn
○ 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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
9	GP Consultation	General Consultati
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
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy
0005-149902-1021	CLOFEN	Pharmacy

Code	Generic	Duration	Instructions
2594-627701-1171	(VITAMIN D3 : 400 IU) (MAGNESIUM : 48 MG) (ZINC : 3.4 MG) (VITAMIN K2 : 90 MCG) (CALCIUM : 320 MG) TABLETS	30	Take 1Tablets 1 Tim 30 Day(s) after mea
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	3	Take 1Tablets 1 Tim 3 Day(s) after meal
0027-149903-0111	(DICLOFENAC SODIUM : 100 MG) COATED TABLETS	3	Take 1Tablets 1Time Day(s) after meal
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	3	Take 1Mg 2 Time(s) Day(s) others

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

Is In-patient Required ? Length of Stay	Indicate Provider
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 ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefts. Medical manage 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 : 23-Mar-2025
Note: Claims must be submited along with supportng 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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX doctors.