

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: RENU NEPALI	Gender: Female	Validity Between: 25/07/2024 and 24/07/2025
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 Ansari-AUH)-MEDGULF
Natonal ID: 784-1988-9284107-7	Service Date: 23-Mar-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0542028723	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent :	
Gatekeeper: No	Patent's File No: 38445	Pharmacy: Co-Part: 20%
Referral No:	Consultaton :	Laboratory: Covered
Referred Service:		

SUBJECTIVE ASSESSMENT

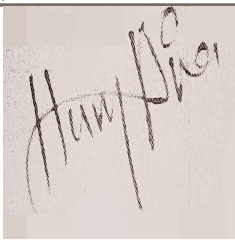
Symptom(s) as described by the patent (Chief Complaint):		Date of Symptoms/illness started	
Complaint		DD	MM
follow up patient			YYYY
in investigation there is WBS high			
which shows infection in body			
Past Medical Surgical History?		☐ Yes	☐ No
		DD	MM
			YYYY
Obs/Gyn Claims		Date of Symptoms/illness 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 :		T :	HR :	RR :
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected						
INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	A49.9	Bacterial infection, unspecified				
Secondary	M54.5	Low back pain				
Secondary	M79.18	Myalgia, other site				

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
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0195-107704-0801	CEFTRIAZONE-TABUK IV	Pharmacy	48.5000
Code	Generic	Duration	Instructions
No Prescriptions History Found			
☐ 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: 54155330-002 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.		Patient's Signature(Parent if minor)	
Date :		Date : 23-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 efects 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.