eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**NAHED ABDULLA SHIKH FARES**	Gender:	**Female**	Validity Between:	**16/11/2024 and 15/11/2025**
Card No:	**8443-578A-6F2D-1E01**	DOB:	**1/11/1986 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1986-6514181-2**	Service Date:	**11-Apr-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0507740340**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**38427**	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 Symptoms/illness started**		
	DD	MM	YYYY
Complaint pc : severe sore thraot , sneezing , cough with sputum , body pain and headche with high grade fever started 10/04/25 took some meds not improved reported again with worsenig of symptoms o/e : look larhgic hyperemic phaeynx congested with swollen tonsils			

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 : 117	T : 38.6	HR : 96	RR : 0

Assessment/Diagnosis : ◯ **Acute** ◯ **Chronic** ◯ **Confirmed** ◯ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R52	Pain, unspecified
Secondary	R05	Cough
Secondary	R06.2	Wheezing
Secondary	E86.0	Dehydration

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
9.01	Follow-up consultation	General Consultation	0.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000

Code	Generic	Duration	Instructions
No Prescriptions History Found			

○ 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	Estimate Cost

I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for*

medically indicated & necessary for the management of this case.	*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 Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)***
Date :	Date : 11-Apr-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 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.