

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	LEWELLEN MISHIN TUHOD	Gender:	Female	Validity Between:	02/07/2024 and 18/06/2025
Card No:	F168-49C8-EA2D-FB85	DOB:	4/8/1971 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1971-0620618-4	Service Date:	17-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0569724103		
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:	46524	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started					
Complaint sore throat dry cough fever headache body pain and low back pain runny nose nasal congestion at night o/e hyperemia and chest congestion known patient of hypertension since 18 years.						DD		MM		YYYY	
Past Medical Surgical History?						☐ Yes		☐ No		Date of Symptoms/illness started	
Obs/Gyn Claims						Date of Symptoms/illness started					
☐ 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)

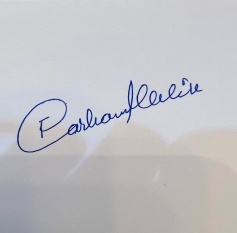
Clinical Findings :				Vital Signs : B/P : 160 T : 37.5 HR : 78 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	I10	Essential (primary) hypertension					
Secondary	J02.9	Acute pharyngitis, unspecified					
Secondary	R05	Cough					
Secondary	M54.5	Low back pain					
Secondary	R09.81	Nasal congestion					

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		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		

CPT Code	Treatment	Type	Price
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	3.1000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800

Code	Generic	Duration	Instructions
0006-106601-0394	(PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 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>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> <i>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.</i>		
Treating Physician Name : Dr.Farhan Iyas		
Tel / Fax (important):		
 Signature & Stamp Dr. Frahan Ilyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E		 Patient's Signature(Parent if minor)
Date :		Date : 17-Apr-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.