

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	ABIN NOORUPARAYIL VARHESE MENAMOOTTIL VARGHESE		Gender:	Male	Validity Between:	01/07/2024 and 30/06/2025
Card No:	EDAC-2F19-8741-123D	DOB:	5/2/1998 12:00:00 AM	Coverage Informaton for:	Out Patient	
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)- MEDGULF	
Natonal ID:	784-1998-2643589-5	Service Date:	19-Apr-2025	Radiology:	Covered	
Policy Holder:		Patent's Tel No:	0544942127			
Payer Name:	NATIONAL GENERAL INSURANCE COMPANY	Threshold Limit:				
		Class:	Normal			
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%	
Gatekeeper:	No	Patent's File No:	46377	Laboratory:	Covered	
Referral No:		Consultaton :				
Referred Service:						

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint					DD	MM	YYYY
EVERE SORE THROAT , BODYPAIN , LETHARGY , SHIVERING AND FEVER STRATRD 17/04/25							
O/E : LOOK PALE , LETHARGIC ,							
DEHYDRATED							
HYPEREMIC PHARYNX							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started	
						DD	MM
						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:							

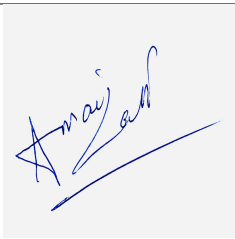
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :			Vital Signs : B/P : 120	T : 37.1	HR : 78	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J02.9	Acute pharyngitis, unspecified				
Secondary	R05	Cough				
Secondary	R50.9	Fever, unspecified				

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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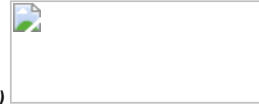
Accident or illness due to work?		Injury due to road accident?		Describe how the accident or work related injury/illness occur:	
☐ Yes ☐ No		☐ Yes ☐ No			
Date of accident or beginning of illness:					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim					
CPT Code	Treatment			Type	Price
9	GP Consultation			General Consultation	25.0000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)			Co.Pay	5.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug			Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular			Co.Pay	10.0000
0005-111805-1021	CHLOROHISTOL 10MG			Pharmacy	1.2000
0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION			Pharmacy	48.5000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE			Pharmacy	1.7000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION			Pharmacy	8.4000
86140	C-reactive protein;			Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count			Lab	20.0000
Code	Generic		Duration	Instructions	
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS		3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal	
2150-575201-1171	(CALCIUM : 400 MG) (VITAMIN D3 : 200 IU) (MAGNESIUM : 100 MG) (ZINC : 4 MG) TABLETS		30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal	
2027-719101-0391	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS		5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal	
0118-114501-1161	(AMBROXOL : 15 MG/5ML) SYRUP		5	Take 10ML 1 Time(s) per Day For 5 Day(s) after meal	
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) after meal	
☐ Pharmacy:		Estimated Costs		☐ Laboratory / Radiology:	
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 benefsts. 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 : 19-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 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.