

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	SANA KASHIF MUHAMMAD KASHIF	Gender:	Female	Validity Between:	23/01/2025 and 22/01/2026
Card No:	BD7A-9CDB-3C37-F132	DOB:	6/25/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-2359601-4	Service Date:	20-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0505029372		
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:	46550	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
PC : HEADACHE , MIGRAINE HX FEELS NAUSEA , VOMITTING , DISCOMFORT ,NOT ABLE TO SLEEP PROPERLY								
HX OF HYPERLIPIDEMIA								
O/E : HIGH BLOOD PRESSURE								
180MMHG								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 180 T : 36.9 HR : 80 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	I10	Essential (primary) hypertension			

Type	Code	Diagnosis
Secondary	R51.9	Headache, unspecified
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	G43.711	Chronic migraine w/o aura, intractable, w status migrainosus
Secondary	R34	Anuria and oliguria

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
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
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	45.0000

Code	Generic	Duration	Instructions
2027-719101-0391	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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
2104-379202-1451	(AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening

☐ 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 : 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 : 20-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

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