

eASOAP FORM


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

Patent Name:	Sadiya Sabuhi	Gender:	Female	Validity Between:	01/03/2025 and 28/02/2026
Card No:	15B8-93D3-6FDF-4F0C	DOB:	5/3/1999 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1999-8943698-7	Service Date:	21-Apr-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0505262400		
Payer Name:	DP World	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	42904	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 : lethargic , tired , diziness , and feel week all started 13/04/25						
o/e : look pale , lethargic dehydrated						
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:						

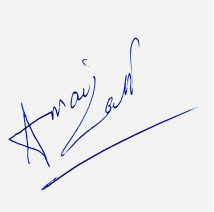
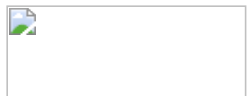
OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings :		Vital Signs : B/P : 126	T : 36.7	HR : 80	RR : 20
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	D50.9	Iron deficiency anemia, unspecified			
Secondary	R03.1	Nonspecific low blood-pressure reading			
Secondary	B76.9	Hookworm disease, unspecified			
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	GP Consultation	General Consultation	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
Code	Generic	Duration	Instructions
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	3	Take 1sachet 2 Time(s) per Day For 3 Day(s) others
0189-109805-1171	(ALBENDAZOLE : 400 MG) TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal
1195-680601-0611	(ZINC : 12 MG) (FOLIC ACID : 500 MCG) (COPPER : 2000 MCG) (CYANOCOBALAMIN : 10 MCG) (PYRIDOXINE : 5 MG) (IRON : 24 MG) MODIFIED RELEASE CAPSULES	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
☐ Surgery:		☐ Endoscopy:	
☐ Physiotherapy:		☐ Other Procedures:	
Is the following required		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 : 21-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.