eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**VIOLY PAGAL 8032047-5**	Gender:	**Female**	Validity Between:	**14/09/2024 and 13/09/2025**
Card No:	**8FA4-D282-210B-5497**	DOB:	**6/17/1977 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1977-8032047-5**	Service Date:	**24-Apr-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0508047363**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46559**	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**		
Complaint	DD	MM	YYYY
dizziness epigastric pain nausea and feeling vomiting weakness headache on investigation there is CRP high			

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 : 120 T : 36.3 HR : 84 RR : 18

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

Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R52	Pain, unspecified
Secondary	R06.7	Sneezing
Secondary	K29.00	Acute gastritis without bleeding

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:		

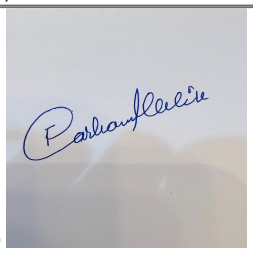
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
0005-174202-0781	RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION	Pharmacy	34.0000
9.01	Follow-up consultation	General Consultation	0.0000
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
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
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
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
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000

Code	Generic	Duration	Instructions
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) before meal

○ 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 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
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 : 24-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.