

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	ISRAA BASSAM	Gender:	Female	Validity Between:	25/09/2024 and 25/09/2025
Card No:	4076-E682-D28A-64CC	DOB:	1/31/1996 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1996-9365012-1	Service Date:	09-May-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0524013308		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	45126	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

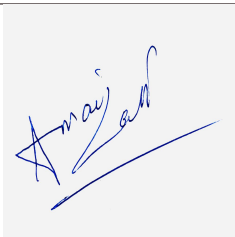
Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint					DD	MM	YYYY
pc : severe swelling of left eye lid causing discomfort and not able to open eye , vision is good and there is didiculty in opening eye associated with severe pain 08 on pain scale and fevre which is low grade o/e : swelling of eye lid and edema							
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 : 130 T : 36.4 HR : 76 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	H10.502	Unspecified blepharoconjunctivitis, left eye					
Secondary	R52	Pain, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	R21	Rash and other nonspecific skin eruption					
Secondary	L03.213	Periorbital cellulitis					

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

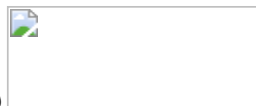
Accident or illness due to work?		Injury due to road accident?		Describe how the accident or work related injury/illness occur:	
☐ Yes ☐ No		☐ Yes ☐ No			
Date of accident or beginning of illness:					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim					
CPT Code	Treatment	Type	Price		
9	GP Consultation	General Consultation	25.0000		
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000		
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000		
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000		
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000		
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	3.1000		
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000		
Code	Generic	Duration	Instructions		
5278-169101-1454	(DOXYCYCLINE : 100 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal		
0027-149904-0172	(DICLOFENAC SODIUM : 50 MG) DISPERSIBLE TABLETS	2	Take 1Tablets 2 Time(s) per Day For 2 Day(s) after meal		
0320-148701-1171	(LORATADINE : 10 MG) TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal		
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal		
0085-227402-0372	(NAPHAZOLINE : 0.025%) (PHENIRAMINE MALEATE : 0.3%) EYE DROPS	5	Take 2Drops 2 Time(s) per Day For 5 Day(s) Left Eye		
☐ 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 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 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 : 09-May-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.