# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **JANNAT FIRDOS** | Gender: | **Female** | Validity Between: | **21/11/2024 and 20/11/2025** |
| Card No: | **1EAD-3006-24FA-8133** | DOB: | **8/15/1990 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1990-2099027-3** | Service Date: | **18-May-2025** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0568012488** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **46017** | 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 |
| history of type 1 hemorrhoids<br>sometimes bleeding<br>history of IBS since 2 months | | | |

| **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 : 118 T : 37.2 HR : 83 RR : 0 |
|---|---|

**Assessment/Diagnosis :** ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | K64.0 | First degree hemorrhoids |
| Secondary | K51.90 | Ulcerative colitis, unspecified, without complications |
| Secondary | K25.3 | Acute gastric ulcer without hemorrhage or perforation |

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

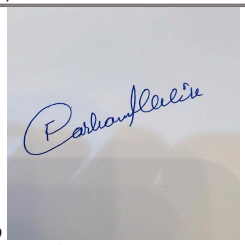
| Accident or illness due to work? | Injury due to road accident? | Describe how the accident or work related injury/illness occur: |
|---|---|---|
| ○ Yes ○ No | ○ Yes ○ No | |
| Date of accident or beginning of illness: | | |

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 |
| 86140 | C-reactive protein; | Lab | 15.0000 |
| 85027 | Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) | Lab | 15.0000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0219-533801-0391 | (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS | 7 | Take 1Tablets 1 Time(s) per Day For 7 Day(s) morning empty stomach |
| 0005-136501-0393 | (HYOSCINE : 10 MG) FILM COATED TABLETS | 7 | Take 1Tablets 2 Time(s) per Day For 7 Day(s) others |
| 0071-158501-0391 | (HESPERIDIN : 50 MG) (DIOSMIN (FLAVONOIDIC FRACTION) : 450 MG) FILM COATED TABLETS | 7 | Take 1Tablets 2 Time(s) per Day For 7 Day(s) others |

| | | | |
|---|---|---|---|
| ○ 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<br>Physician-General Practitioner<br>DHA-06441782-001<br>CITICARE MEDICAL CENTER<br>DUBAI U.A.E | ***Patient's Signature(Parent if minor)***  | |
| Date : | Date : 18-May-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.