eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**QASSEM MOHAMMAD ALKURDI**	Gender:	**Male**	Validity Between:	**23/01/2025 and 22/01/2026**
Card No:	**29D8-1EE3-FE35-C0DB**	DOB:	**8/1/2001 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2001-2094681-7**	Service Date:	**23-May-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0559804161**		
Policy Holder:		Threshold Limit:			
Payer Name:	**AL SAGR NATIONAL INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**38877**	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
pc : sore throat and pain radiating to eras causing discomfort and not able to sleep sever bodypain 07 on pain scale associated with cough with sputum and low grade fever took panadol not improved o/e : look pale , lethargic hyperemic pharynx , tonsils are swollen			

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 : 123	T : 36.8	HR : 81	RR : 18

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

Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	R52	Pain, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	E16.2	Hypoglycemia, unspecified
Secondary	E79.0	Hyperuricemia w/o signs of inflam arthrit and tophaceous dis
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
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
84550	Uric acid; blood	Lab	15.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
82948	Glucose; blood, reagent strip	Lab	10.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	Pharmacy	8.4000

Code	Generic	Duration	Instructions
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) evening
2027-560101-0391	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after 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 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 : 23-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.