

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AMIR SHAHZAD ALLAH YAR	Gender:	Male	Validity Between:	10/06/2025 and 09/06/2026
Card No:	144E-DCF2-8841-29CF	DOB:	8/10/2000 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2000-2342260-1	Service Date:	11-Jun-2025	Radiology:	Covered
		Patent's Tel No:	0554541865		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	47102	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

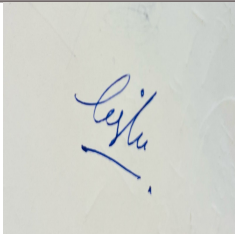
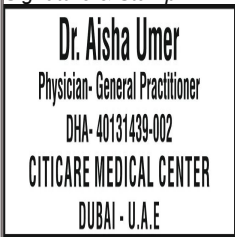
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint pt came with the complain of left sided fascial weakness for the last one day . complain of pain at the back of left ear . on exam he has difficulty to blinking of left eye also . weakness at the left side of face . unable to blown air in the mouth smile is moving toward right side					DD	MM	YYYY
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 : 140	T : 36.8	HR : 76	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	R29.810	Facial weakness			
Secondary	G51.9	Disorder of facial nerve, unspecified			
Secondary	K29.00	Acute gastritis without bleeding			
Secondary	B00.9	Herpesviral infection, unspecified			

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
9	GP Consultation	General Consultation	25.0000
Code	Generic	Duration	Instructions
1312-377901-0371	(POLYETHYLENE GLYCOL 400 : 4 MG/ML) (PROPYLENE GLYCOL : 3 MG/ML) EYE DROPS	15	Take 2Drops 4 Time(s) per Day For 15 Day(s) others
0005-119803-1172	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0207-533802-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 40 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) every morning before breakfast
8033-394001-0391	(VALACICLOVIR (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	5	Take 2Tablets 3 Time(s) per Day For 5 Day(s)
☐ 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>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>		
<i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : AISHA		
Tel / Fax (important):		
 Signature & Stamp		
 Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E		 Patient's Signature(Parent if minor)
Date :		Date : 11-Jun-2025
Note: Claims must be submitted 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 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.