

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AYOUB QASIM MUHAMMAD QASIM	Gender:	Male	Validity Between:	11/10/2024 and 10/10/2025
Card No:	B3C1-0B18-941C-0D38	DOB:	4/2/1998 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1998-8363899-3	Service Date:	20-Jun-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0507083788		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	34230	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 pc : swelling and redness of conjutiva , causing sevre discomfort , photosensitivity started 18/06/25 previous hx of allergic rhinitis o/e : conjutiva is red and congested , both eyes						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			
☐ 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 anv 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 : 100	T : 36.8	HR : 62	RR :
	: 18			

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

Type	Code	Diagnosis
Primary	J30.9	Allergic rhinitis, unspecified
Secondary	H10.13	Acute atopic conjunctivitis, bilateral
Secondary	R52	Pain, unspecified
Secondary	H10.523	Angular blepharoconjunctivitis, bilateral
Secondary	S80.811A	Abrasion, right lower leg, initial encounter

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
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
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
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

Code	Generic	Duration	Instructions
0085-227402-0372	(NAPHAZOLINE : 0.025%) (PHENIRAMINE MALEATE : 0.3%) EYE DROPS	3	Take 2Drops 2 Time(s) per Day For 3 Day(s) others
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	3	Take 1Tablets 1Time(s) perDay For 3 Day(s) after meal
0085-217401-0381	(DEXAMETHASONE : 1 MG/G) (NEOMYCIN : 3500 IU/G) (POLYMYXIN B : 6000 IU/G) EYE OINTMENT	3	apply in both eyes

☐ 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 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>	<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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>	
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		

Amaizah

Signature & Stamp



Patient's Signature(Parent if minor)

Date :

Date : 20-Jun-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.