

eASOAP FORM ADMINISTRATIVE The member is allowed for Out Patient at the CITICARE MEDICAL CENTER LLC SUVITHMOL Patent Name: PADANNAYIL PAVITHRAN Gender: Female Validity Between: 25/06/2024 and 24/06/2025 **PAVITHRAN** 5/7/1981 12:00:00 Coverage Informaton CFAB-2BEF-8F58-0DF1 Card No: DOR: **Out Patient** for: RN UAE (Al Ansari-AUH)-Pin #: Network: Identty Card: **MEDGULF** Natonal ID: 784-1981-5404141-6 Service Date: 22-Jun-2025 Radiology: Covered Patent's Tel No: 0504266973 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File Category B 47201 Co-Part: 20% Category: Pharmacy: No: Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started DD MM YYYY Complaint follow up: crp: 5.6 Date of Symptoms/illness started ○Yes O No Past Medical Surgical History? loo MM YYYY Date of Symptoms/illness started Obs/Gyn Claims 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? \bigcirc Yes \bigcirc No $\,$ if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings : Vital Signs: B/P:118 T:36.8 HR: 78 RR : 18 Assessment/Diagnosis : O Acute O Chr INDICATE DIAGNOSIS NOT SYMPTOM O Chronic ○ Confirmed Suspected Type Diagnosis Primary J02.9 Acute pharyngitis, unspecified

11111dry 302.5			Acute priary	ngitis, unspecificu		
Secondary	R50.9		Fever, unspecified			
Secondary	R19.7		Diarrhea, unspecified			
Secondary	K29.00		Acute gastritis without bleeding			
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)						
IAccident or illness due to work?		Injury due accident?		Describe how the accident or work related injury/illness occur:		
○ Yes ○ No		No				
Date of accident or beginning of	illness:					

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / F	Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Туре	Price
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704- 0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000

Code	Generic			Duration	Instructions		
0207-533801- 1451	(ESOMEPRAZO (HARD GELATI	MEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES D GELATIN)			Take 1Tablets 2 Time(s) per Day For 5 Day(s) before meal		
0415-200001- 1452	(LOPERAMIDE	· / M(-) (APNIII FN (HARI) (-FI AIIN)				ake 1Tablets 2 Time(s) per Day For 5 Day(s) thers	
O Pharmacy:		Estmated Costs	OLabora	atory / Radio	ology:	Estmated Costs	
Is the following required		O Surgery:	○ Endoscopy:				
		O Physiotherapy:	Other Procedures:				
			If yes please specify				

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 condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: AISHA Tel / Fax (important): Signature & Stamp Dit Aisha Umer Physican General Praditione DHA-4031499-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Patient's Signature(Parent if minor) Date: Date: Date: 22-Jun-2025	5				
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Aisha Umer Physician-Ganeal Practioner DHA-0031439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E. Patient's Signature(Parent if minor) Date : Date : 22-Jun-2025	Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost		
medically indicated & necessary for the management of this case. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Or. Aisha Umer Physician General Practitioner OHA-40131439-002 CITICARE MEDICAL CENTER OUBAI-U.A.E. Patient's Signature(Parent if minor) Date : Date : Date : 22-Jun-2025	I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton			
this case. Treating Physician Name : AISHA Tel / Fax (important): Signature & Stamp Dr. Aisha Uner Physician General Practitioner DHA 4031439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Patient's Signature(Parent if minor) Date : Date : 22-Jun-2025	& that the medical services shown on this form were	to release any informaton regarding my medical conditon and history to NEXtCARE			
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 : 22-Jun-2025	medically indicated & necessary for the management of	for the purpose of determining insurance benefts. Medical management is the sole			
Tel / Fax (important): Signature & Stamp Dr. AİSha Umer Physician- General Practitioner DHA-40131439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Patient's Signature(Parent if minor) Date: Date: 22-Jun-2025	this case.	responsibility of doctor and the patent.			
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: Date: 22-Jun-2025	Treating Physician Name : AISHA				
Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E Patient's Signature(Parent if minor) Date: Date:	Tel / Fax (important):				
Note: Claims must be submited along with supportng documents within 30 days from date of service	OHA-40131439-002 CITICARE MEDICAL CENTER DUBAI-U.A.E Date:	Patient's Signature(Parent if minor) Date: 22-Jun-2025			

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 final opinion will be given by the NEXtCARE claims doctors.