

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	BASHARAT ALI MUHAMMAD TARIQ	Gender:	Male	Validity Between:	16/11/2024 and 15/11/2025
Card No:	A1AB-496E-6A65-0192	DOB:	3/6/1989 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-6869092-9	Service Date:	23-Jun-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0509384669		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :			
Gatekeeper:	No	Patent's File No:	45815	Pharmacy:	Co-Part: 20%
Referral No:		Consultaton :		Laboratory:	Covered
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started			
Complaint				DD	MM	YYYY	
C : SORE THROAT , BODYPAIN , FEVER STARTED 20/06/25							
O/E : LOOK LETHARGIC							
DEHYDRATED							
SWOLLEN TONSILLS WITH PUS POINTS							
HYPEREMIC PHARYNX							
CHEST CONGESTED							
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 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 : 120		T : 38.6	HR : 82	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected						
INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J03.91	Acute recurrent tonsillitis, unspecified				
Secondary	R50.9	Fever, unspecified				
Secondary	R52	Pain, unspecified				
Secondary	R05	Cough				
Secondary	J30.9	Allergic rhinitis, unspecified				

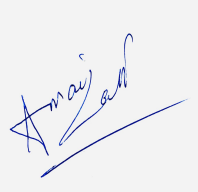
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	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
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0195-107704-0802	CEFTRIAZONE-TABUK IM	Pharmacy	48.5000

Code	Generic	Duration	Instructions
2027-560101-0391	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal
0397-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) 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	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening
0005-116801-1161	(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	7	Take 15ML 2 Time(s) per Day For 7 Day(s) after meal

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
☐ Surgery: ☐ Endoscopy: ☐ Physiotherapy: ☐ Other Procedures:			
Is the following required		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
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 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.	
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		
 Signature & Stamp 		
Date :	Date : 23-Jun-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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