

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MUNA T J KLAIB	Gender:	Female	Validity Between:	01/01/2024 and 31/12/2026
Card No:	33DB-EBD3-DBC4-5FF1	DOB:	12/11/1993 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1993-0351514-4	Service Date:	26-Jun-2025	Radiology:	Covered
		Patent's Tel No:	0562906355		
Policy Holder:		Threshold Limit:			
Payer Name:	ENAYA	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	34084	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 : SORE THROAT , SNEEZING , RUNNY NOSE , FRONTAL HEADACHE , COUGH WITH CLEAR SPUTUM OCCASIONALLY O/E : LOOK IRRITABLE RED CONJUCTIVA BOTH EYES HYPEREMIC PHARYNX					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 : 116 T : 36 HR : 94 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J02.9	Acute pharyngitis, unspecified	
Secondary	J30.9	Allergic rhinitis, unspecified	
Secondary	R05	Cough	

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

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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	Consultation GP	General Consultation	60.0000		
86140	C-reactive protein;	Lab	25.2000		
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	65.0000		
Code	Generic	Duration	Instructions		
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	5	Take 15ML 2 Time(s) per Day For 5 Day(s) after meal		
6705-602505-3801	(HYDROXYPROPYLMETHYLCELLULOSE : 150 MG/ 30ML) SPRAY SOLUTION	3	Take 1Spray 2 Time(s) per Day For 3 Day(s) after meal		
2027-719101-0392	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal		
☐ 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 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		 Patient's Signature(Parent if minor)			
					
Date :		Date : 26-Jun-2025			
Note: Claims must be submitted along with supporting documents within 30 days from date of service					

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