

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	LUCY NJOKI	Gender:	Female	Validity Between:	30/04/2025 and 29/04/2026
Card No:	9894-2C1F-1EFD-5321	DOB:	4/6/1993 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-1993-9193872-9	Service Date:	27-Jun-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0566183501		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	46365	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

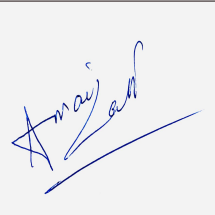
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
SORE THROAT NAUSEA , EARACHE , AND SNEEZING , NASAL BLOCAGE STARTED 25/06/25 SHOULDER PAIN ON RT SIDE RADIATING TO MID BACK CAUSING DISCOMFORT AND MOVEMENT IS AFFECTED STARTED 26/06/25 TOOK SOME ANALGESIC BUT NOT IMPROVED O/E : LOOK LETHARGIC , DEHYDRATED , OVERHEAD ABDUCTION IS LIMITED ON RT SIDE								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						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 : 124 T : 36.8 HR : 76 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J01.41	Acute recurrent pansinusitis			
Secondary	R19.7	Diarrhea, unspecified			
Secondary	R52	Pain, unspecified			
Secondary	J30.9	Allergic rhinitis, unspecified			
Secondary	E86.0	Dehydration			
Secondary	R11.2	Nausea with vomiting, 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
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
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
Code	Generic	Duration	Instructions
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	3	Take 1sachet 1 Time(s) per Day For 3 Day(s) others
2027-719101-0392	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 MG) FILM COATED TABLETS	3	Take 1Tablets 2Time(s) perDay 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
☐ 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 benefets. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		
 Signature & Stamp Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	 Patient's Signature(Parent if minor)	
Date :	Date : 27-Jun-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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