eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out Patient** at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	**ABRISH KHAN FAHEEM KHAN**	Gender:	**Female**	Validity Between:	**04/09/2024 and 03/09/2025**
Card No:	**3181-8790-78D8-E07A**	DOB:	**3/28/2018 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2008-8412250-1**	Service Date:	**09-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0569200125**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37192**	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	DD	MM	YYYY
itching in perineal area at night time cough at night time and early morning no suspicion of abuse. on exam: inflamed perineum secondary to itching Chest is clear. rest of the systemic examination : unremarkable.			

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 : 00	T : 36.5	HR : 100	RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	B80	Enterobiasis
Secondary	D50.9	Iron deficiency anemia, unspecified

Type	Code	Diagnosis
Secondary	E55.9	Vitamin D deficiency, 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
81007	Urinalysis; bacteriuria screen, except by culture or dipstick	Lab	8.0000
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Lab	100.0000
82728	Ferritin	Lab	20.0000
83540	Iron	Lab	20.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
F67-5477-05016-01	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	5	Take 0.5ML 2 Time(s) per Day For 5 Day(s) before meal, add 3 ml normal saline in 0.5 ml ventolin
6396-925801-3851	(SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY	5	Take 1Drops 1 Time(s) per Day For 5 Day(s) evening
0096-130804-0151	(DEXPANTHANOL : 50 MG/G) CREAM	3	Take 1Cream 2 Time(s) per Day For 3 Day(s) others
0215-109803-1111	(ALBENDAZOLE : 100 MG/5ML) SUSPENSION	1	Take 20ML 1 Time(s) per Day For 1 Day(s) others, repeat dose after 2 weeks

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 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 conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Dr Bushra**		
Tel / Fax (important):		
Signature & Stamp Dr. Bushra Mufti General practitioner DHA: 75646242-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)***	
Date :	Date : 09-Jul-2025	

Note: Claims must be submited along with supportng documents within 30 days from date of service

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

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