

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 Information 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
Policy Holder:		Patent's Tel No:	0569200125		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	37192	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint 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.						DD	MM	YYYY
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 : 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)

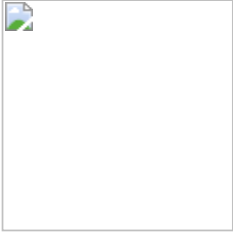
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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:	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>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>		<i>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 benefits. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : Dr Bushra		
Tel / Fax (important):		
		
Signature & Stamp 		
Date :		Date : 09-Jul-2025
Note: Claims must be submitted along with supporting 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 effects caused due to the claims submissions. NEXtCare assumes no

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