

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**at the **CITICARE MEDICAL CE**

Patent Name:	REHANA BIBI KHAN	Gender:	Female	Validity Between:	07/02/2025 and (
Card No:	CECA-ABE5-98BE-230C	DOB:	6/7/1972 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans; MEDGULF
Natonal ID:	784-1972-9947102-5	Service Date:	10-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0565429797		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	46235	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 Symptom	
Complaint pc : left lumber pain hopc : pt came with low back pain that radiates towards pelvis she is diabetic ,hypertensive and having hypercholesterolimia previous hbaic is 18						DD	MM
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptom	
						DD	MM
Obs/Gyn Claims						Date of Symptom	
						DD	MM
☐ 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 : 92 : 18	T : 37	HR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			

Type	Code	Diagnosis
Primary	I10	Essential (primary) hypertension
Secondary	R73.9	Hyperglycemia, unspecified
Secondary	E78.00	Pure hypercholesterolemia, unspecified
Secondary	R30.0	Dysuria
Secondary	M54.5	Low back pain
Secondary	K76.0	Fatty (change of) liver, not elsewhere classified
Secondary	R14.3	Flatulence

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

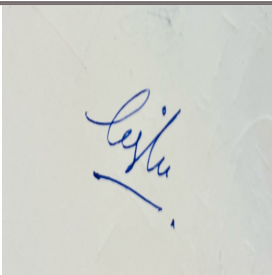
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illn
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type
9	GP Consultation	General Consultat
80076	Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)	Lab
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	Lab
82947	Glucose; quantitative, blood (except reagent strip)	Lab
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab

Code	Generic	Duration	Instructions
5254-830602-2401	(VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS	30	Take 1Tablet Day For 30 D
1516-151709-0081	(SIMETHICONE : 42 MG) CHEWABLE TABLETS	7	Take 1Tablet Day For 7 Da
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	5	Take 1Tablet Day For 5 Da
0135-223402-1171	(NAPROXEN : 250 MG) TABLETS	5	Take 1Tablet Day For 5 Da
6619-548302-0251	(SODIUM BICARBONATE : 1.76G) (SODIUM CITRATE ANHYDROUS : 0.63G) (TARTARIC ACID : 0.89G) (CITRIC ACID ANHYDROUS : 0.715 G) EFFERVESCENT GRANULES	5	Take 1sachet perDay For 5

☐ 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
<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 ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefets. Medical manage responsibility of doctor and the patent.</i>
Treating Physician Name : AISHA	
Tel / Fax (important):	
 Signature & Stamp Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	 Patient's Signature(Parent if minor)
Date :	Date : 10-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 rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX doctors.