

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	KAMAL MUSLIYARPARAMBIL ABDUL KADER MADATHANKANDY	Gender:	Male	Validity Between:	31/12/2024 and 30/12/2025
Card No:	317F-9C1E-D89F-4476	DOB:	1/1/1973 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1973-1306437-6	Service Date:	16-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0562620032		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	30760	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
PC fever,headache,running nose,cough,nasal block							
HOPC pt presented with complaints of fever,running nose,nasal block,cough since 3 days							
O\E Chest clear,Pt conscious oriented							
Nil comorbs							
No history of drug allergy							
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 : 128		T : 36.6	HR : 82	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R50.9	Fever, unspecified					
Secondary	J30.9	Allergic rhinitis, unspecified					
Secondary	R05	Cough					
Secondary	R51.9	Headache, unspecified					

Type	Code	Diagnosis
Secondary	E78.5	Hyperlipidemia, 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
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	45.0000
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300
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
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000

Code	Generic	Duration	Instructions
0097-393801-2471	(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	5	Take 5Syrup 2 Time(s) per Day For 5 Day(s) others
0006-106601-0394	(PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 3 Time(s) per Day For 3 Day(s) others
6891-929502-2022	(XYLOMETAZOLINE HCL : 0.1% W/V) NASAL DROPS	5	Take 1Drops 3Time(s) perDay For 5 Day(s) others
5098-108101-0392	(DESLORATADINE : 5 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others

☐ 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 : KEERTHANA		
Tel / Fax (important):		

Signature & Stamp د. كيرثانا راني باديبورايل ثارا Dr. Keerthana Rani Padippurayil Thara General Practitioner License No.: 37864046-001 مركز سيتيكير الطبي ذم م CITICARE MEDICAL CENTER LLC	Patient's Signature(Parent if minor)
Date :	Date : 16-Jul-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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