

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CE**

Patent Name:	HELEENA LANY VARGHEESE VARGHEESE PHILIP	Gender:	Female	Validity Between:	08/02/2025 and
Card No:	ADD2-9203-BF04-FFED	DOB:	11/14/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ans MEDGULF
Natonal ID:	784-1989-6909137-4	Service Date:	16-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0544995167		
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:	47406	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Sympton	
Complaint PC Headache,bodypain,fever,sorethroat,cough HOPC Pt presented with complaints of high grade fever,cough with yellow sputum,ear ache,sorethroat since 1 day Family history of fever present No comorbs No history of drug allergy O\E Chest clear Tonsils erythemtous Ear examination normal						DD	MM
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptor	
						DD	MM
Obs/Gyn Claims						Date of Symptor	
						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 : 106 : 18	T : 38	HR
---------------------	---------------------------------	--------	----

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	E86.0	Dehydration
Secondary	R05	Cough
Secondary	R51.9	Headache, unspecified
Secondary	H92.03	Otalgia, bilateral
Secondary	R07.0	Pain in throat
Secondary	R52	Pain, unspecified
Secondary	K29.00	Acute gastritis without bleeding

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:		

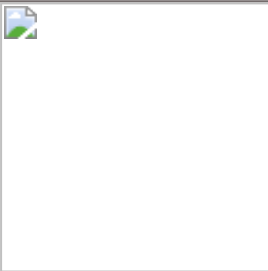
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay
9	GP Consultation	General Consultati
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy
86141	C-reactive protein; high sensitivity (hsCRP)	Lab
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab

Code	Generic	Duration	Instructions
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	5	Take 1Tablets 2 Tin 5 Day(s) others

Code	Generic	Duration	Instructions
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 1 Tin 5 Day(s) others
0250-125820-3931	(POVIDONE IODINE : 1%) MOUTHWASH-SOLUTION	3	Take 5Solution 3 Ti For 3 Day(s) others
0097-393801-2471	(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	5	Take 5Syrup 3 Time 5 Day(s) others
5122-108101-0391	(DESLORATADINE : 5 MG) FILM COATED TABLETS	3	Take 1Tablets 1 Tin 3 Day(s) others
2027-560101-0391	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 3 Tin 3 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	
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 ot to release any informaton regarding my medical conditon and histo for the purpose of determining insurance benefets. Medical manage responsibility of doctor and the patent.	
Treating Physician Name : KEERTHANA			
Tel / Fax (important):			
 Signature & Stamp		 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

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 effects 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.