

eASOAP FORM



ADMINISTRATIVE

The member is allowed for Out Patientat the CITICARE MEDICAL CENTER LLC

Patent Name:	SAMIR DIGE ARUN SONU DIGE	Gender:	Male	Validity Between:	12/09/2024 and 11/09/2025
Card No:	1008-002-117012031-04	DOB:	6/21/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-0843274-3	Service Date:	19-Jul-2025	Radiology:	Covered
		Patent's Tel No:	0526196000		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	45947	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
PC fever,bodypain,sorethroat,headache since 2 days							
He has abdominal cramps following antibiotic intake							
O\E chest clear							
Tonsils inflamed and infected							
No history of drug allergy							
Nil comorbs							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					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 : 120 : 18	T : 38.8	HR : 110	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				
Type	Code	Diagnosis		
Primary	J03.90	Acute tonsillitis, unspecified		
Secondary	R50.9	Fever, unspecified		
Secondary	R51.9	Headache, unspecified		
Secondary	R07.0	Pain in throat		

Type	Code	Diagnosis
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/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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0195-107704-0801	CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
9.01	Follow-up consultation	General Consultation	0.0000

Code	Generic	Duration	Instructions
1647-119814-1171	(PREDNISOLONE : 10 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0250-125808-1741	(POVIDONE IODINE : 1%) GARGLE	3	Take 5Solution 3 Time(s) per Day For 3 Day(s) others
0005-101701-0392	(ACECLOFENAC : 100 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	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 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 other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefets. Medical management is the sole responsibility of doctor and the patent.
Treating Physician Name : KEERTHANA		
Tel / Fax (important):		
Signature & Stamp  		 
Date :	Date : 19-Jul-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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