

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	AAMIR RASHEED MUHAMMAD RASHEED	Gender:	Male	Validity Between:	06/12/2024 and 05/12/2025
Card No:	7735-027D-BB72-9AEA	DOB:	4/4/1984 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1984-8194090-0	Service Date:	20-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0501440709		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	47429	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
Came for followup of general package Pt complaints of burning sensation in both feet since 3 months Vit D3 15.1 Hba1c 10.5 Triglyceride 245 FBS 101 He has started OHA 2 WEEKS BACK AND THE Hba1c dropped from 12 to 10.5								
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 : 126 T : 36.8 HR : 94 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	E55.9	Vitamin D deficiency, unspecified			

Type	Code	Diagnosis
Secondary	E11.9	Type 2 diabetes mellitus without complications
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	E78.5	Hyperlipidemia, unspecified

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

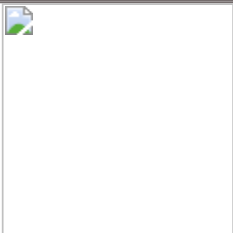
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0042-538302-0391	(METFORMIN HCL : 850 MG) (LINAGLIPTIN : 2.5 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
1350-854601-0391	(EZETIMIBE : 10 MG) (ROSUVASTATIN (AS CALCIUM) : 10 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0118-114201-1171	(GLIMEPIRIDE : 2 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0207-211505-1171	(FENOFIBRATE : 145 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
2693-382607-0971	(ERGOCALCIFEROL (VITAMIN D2) : 50000 IU) SOFT GELATIN CAPSULES	8	Take 1Tablets 1 Time(s) per Day per week For 8 weeks others
6189-909901-1171	(MECOBALAMIN : 0.5 MG) (FURSULTIAMINE HCL : 36.4 MG) (TOCOPHEROL CALCIUM SUCCINATE : 34.5 MG) (PYRIDOXINE HYDROCHLORIDE : 33.3 MG) (NICOTINAMIDE : 20 MG) (CALCIUM PANTOTHENATE : 15.4 MG) (GAMMA ORYZANOL : 3.3 MG) (FOLIC ACID : 0.3 MG) TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

☐ 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : KEERTHANA		
Tel / Fax (important):		
 Signature & Stamp		 Patient's Signature(Parent if minor)
		

Date :	Date : 20-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 creation 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 responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.