

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	NADEEM KHAN HAKIM KHAN	Gender:	Male	Validity Between:	23/09/2024 and 22/09/2025
Card No:	7ECB-B800-04BA-1D0C	DOB:	1/1/1981 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1981-0295361-3	Service Date:	20-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0556593294		
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:	45202	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,BODYPAIN,THROAT PAIN,COUGH SINCE YESTERDAY HOPC pt presented with complaints of fever,bodypain,headache,sorethroat and couh since yesterday No drug allergy Nil comorbs O\E Chest clear TONSILS NORMAL							
Past Medical Surgical History?					☐ 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 : 122 T : 39 HR : 86 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	R50.9	Fever, unspecified	
Secondary	R51.9	Headache, unspecified	
Secondary	R05	Cough	
Secondary	R07.0	Pain in throat	

Type	Code	Diagnosis
Secondary	R52	Pain, 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
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000

Code	Generic	Duration	Instructions
0005-101701-0392	(ACECLOFENAC : 100 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0837-277601-1161	(OXOMEMAZINE : 0.33 MG/ML) SYRUP	5	Take 5Syrup 3 Time(s) per Day For 5 Day(s) others
0006-106601-0392	(PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 3 Time(s) per Day For 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	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  		 
Date :	Date : 20-Jul-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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