

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	NAHED ABDULLA SHIKH FARES	Gender:	Female	Validity Between:	16/11/2024 and 15/11/2025
Card No:	8443-578A-6F2D-1E01	DOB:	1/11/1986 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1986-6514181-2	Service Date:	22-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0507740340		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	38427	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC pt presented with complaints of pain,swelling and difficulty in bending the left middle finger HOPC pt had a trauma to left MIDDLE finger with glass piece while working in kitchen on JUN 30,2025 following which she is unable to bend the finger properly.She also has pain She is a housewife O\E there is thick redish purple skin bw interphalayngeal joint along with swelling and pain follow up pt also has high grade fever with generalize body pain her crp is high 15.5 advice x ray and mri to rule out any internal injury						DD	MM	YYYY
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 : 120	T : 37.7	HR : 92	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	L03.012	Cellulitis of left finger
Secondary	R50.9	Fever, unspecified
Secondary	R52	Pain, unspecified
Secondary	E86.0	Dehydration
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:		

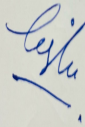
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
0439-152905-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
9.01	Follow-up consultation	General Consultation	0.0000
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	Pharmacy	6.5000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000

Code	Generic	Duration	Instructions
0005-107001-0052	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
0077-258502-1171	(SODIUM AESCINATE : 20 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0009-122302-0391	(ETORICOXIB : 120 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) empty stomach
0397-116207-0391	(AMOXICILLIN : 500 MG) (CLAVULANIC ACID : 125 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 : AISHA		
Tel / Fax (important):		

 Signature & Stamp Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	 Patient's Signature(Parent if minor)
Date :	Date : 22-Jul-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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