

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	BINDU RANI PRABHAKARAN NAIR NARAYANAN PARETHODI	Gender:	Female	Validity Between:	24/05/2025 and 23/05/2026
Card No:	F2BF-7DC4-38CD-4EE7	DOB:	11/11/1969 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1969-1732905-2	Service Date:	22-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0505317751		
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:	47025	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 localized pain sole of left foot HOPC PT PRESENTED WITH COMPLAINTS OF PAIN IN THE CENTRE OF LEFT SOLE OF FOOT AFTER WEARING NEW POINTED SHOES ON 14-7-2025 WHICH CAN PROBABLY AN INJURY She is a housewife O\E Contusion present over centre of sole Mild tenderness present,sensation present Pt gives a history of new sandal used one week back K\C\O DM Vit D3 14						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 : 110	T : 36.8	HR : 78	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	S90.32XS	Contusion of left foot, sequela
Secondary	S99.922S	Unspecified injury of left foot, sequela
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
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
6506-931301-1451	(ZINC GLUCONATE : 97.58 MG) (IRON (FERROUS FUMARATE) : 76.07 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 6.07 MG) (CUPRIC CITRATE (COPPER) : 5.68 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 1 MG) (PTEROYLMONOGLUTAMIC ACID : 500 MCG) CAPSULES (HARD GELATIN)	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 Week For 8 Day(s) others
0077-258502-1171	(SODIUM AESCINATE : 20 MG) TABLETS	3	Take 1Tablets 2 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 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 : 22-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 reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.