

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

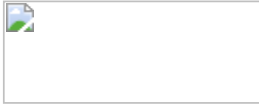
Patent Name:	HANIA AHMAD AHMED NAWAZ	Gender:	Female	Validity Between:	09/12/2024 and 08/12/2025
Card No:	B873-B9F4-2994-D38C	DOB:	1/6/2023 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2023-7941827-4	Service Date:	25-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0551082308		
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:	45978	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,loose stools,vomiting,cough								
HOPC she was in pakistan 2 days back.She had fever,loose motion,vomiting and cough since one week.She is not eating properly								
O\E child active and alert,dehydrated								
She was not drinking ors								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:	DD	MM	YYYY
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 : 00		T : 37.7		HR : 102		RR	
				: 24							
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected											
INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	R50.9	Fever, unspecified									
Secondary	R05	Cough									
Secondary	R19.7	Diarrhea, unspecified									
Secondary	R11.2	Nausea with vomiting, 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
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
Code	Generic	Duration	Instructions
1342-383401-0451	(LACTOBACILLUS ACIDOPHILUS : 107 MG) (BIFIDOBACTERIUM INFANTIS : 107 MG) (LACTOBACILLUS CASEI : 107 MG) (LACTOBACILLUS LACTIS : 107 MG) (BIFIDOBACTERIUM BIFIDUM : 107 MG) (BIFIDOBACTERIUM LONGUM : 107 MG) GRANULES	5	Take 1sachet 1 Time(s) per Day For 5 Day(s) others
0097-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	3	Take 1Solution 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 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):			
			
د. کیرثانا رانی پادیپورایل ثارا Dr. Keerthana Rani Padippurayil Thara General Practitioner License No.: 37864046-001 مرکز سیتی کیر الطبی ذم م CITICARE MEDICAL CENTER LLC		Patient's Signature(Parent if minor)	
Date :		Date : 25-Jul-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service			

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