eASOAP FORM

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

Patent Name:	**ZOHAIB UL HASSAN MUHAMMAD**	Gender:	**Male**	Validity Between:	**16/06/2025 and 15/06/2026**
Card No:	**CC58-9802-AEA8-3ED6**	DOB:	**7/28/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-3910752-6**	Service Date:	**27-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0521451348**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47263**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):	**Date of Symptoms/illness started**		
Complaint	DD	MM	YYYY
PC sorethroat,body weakness,bodypain HOPC pt presented with complaints of sorethroat,bodypain, assocaited weakness since yesterday No history of drug allergy Nil comorbs O\E chest clear Throat hyperemic			

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 : 37 HR : 72 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J03.90	Acute tonsillitis, unspecified
Secondary	R07.0	Pain in throat
Secondary	R50.9	Fever, unspecified

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

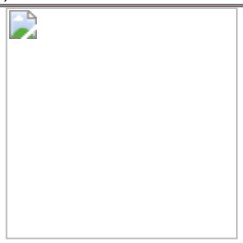
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000

Code	Generic	Duration	Instructions
0096-106304-0271	(ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
1839-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0250-125808-1741	(POVIDONE IODINE : 1%) GARGLE	5	Take 5 Unit(s), 3 Time(s) per Day For 5 Day(s)
0006-106601-0392	(PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 3 Time(s) per Day For 3 Day(s) others

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 certfy 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **KEERTHANA**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 27-Jul-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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