

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	NOOR NIDAL N A SAWALHA	Gender:	Male	Validity Between:	13/06/2025 and 12/06/2026
Card No:	A820-A9E0-F001-2C07	DOB:	1/28/2002 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2002-7971021-2	Service Date:	27-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0553620074		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44372	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 fever,headache,bodypain,cough,running nose,sorethroat HOPC pt presented with complaints of fever,bodypain,cough,running nose since yesterday No history of dug allergy Nil comorbs o\e Chest clear TONSILS ERYTHEMATOUS						
Past Medical Surgical History?			☐ Yes	☐ No	Date of Symptoms/illness started	
					DD	MM
					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 : 37.4	HR : 106	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	J03.90	Acute tonsillitis, unspecified				
Secondary	R50.9	Fever, unspecified				
Secondary	R05	Cough				
Secondary	J30.9	Allergic rhinitis, unspecified				

Type	Code	Diagnosis
Secondary	K29.60	Other 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
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
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
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0188-135906-2441	PULMICORT-(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	Pharmacy	10.4800
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
0207-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
5363-571401-1161	(TRIPROLIDINE HCL : 1.25 MG/5ML) (GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) SYRUP	5	Take 5Syrup 3 Time(s) per Day For 5 Day(s) others
4066-108101-0391	(DESLORATADINE : 5 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 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 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>	<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 د. كيرثانا راني باديبورايل ثارا Dr. Keerthana Rani Padippurayil Thara General Practitioner License No.: 37864046-001 مركز سيتيكير الطبي ذم م CITICARE MEDICAL CENTER LLC	Patient's Signature(Parent if minor)
Date :	Date : 27-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 creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.