

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MUHAMMAD HAIDER ALI USMAN	Gender:	Male	Validity Between:	23/07/2025 and 22/07/2026
Card No:	C07C-6D52-0FB0-58EA	DOB:	11/3/2023 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-2023-5522579-2	Service Date:	30-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0502295430		
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:	45495	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

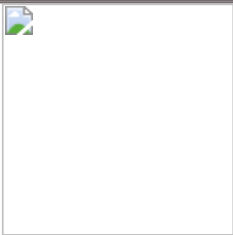
Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started		
Complaint				DD	MM	YYYY
PC fever HOPC pt presented with complaints of fever that started one hour back O\E child crying,active Chest clear Tonsils normal Advised tepid sponging						
Past Medical Surgical History?				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 : 38.7	HR : 100	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	R50.9	Fever, unspecified			
Secondary	J30.9	Allergic rhinitis, 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	
Code	Generic	Duration	Instructions	
0205-123704-1631	(CETIRIZINE : 10 MG/ML) DROPS (ORAL)	5	Take 0.5Syrup 1Time(s) perDay For 5 Day(s) others	
0005-106606-1112	(PARACETAMOL : 250 MG/5ML) SUSPENSION	3	Take 3Syrup 4 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):			
 			
Date :		Date : 30-Jul-2025	
Note: Claims must be submitted along with supportng 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 effects 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.