eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**Muhammad Umer**	Gender:	**Male**	Validity Between:	**01/07/2025 and 30/06/2026**
Card No:	**I008-002-115012620-01**	DOB:	**7/23/1990 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1990-2814637-3**	Service Date:	**30-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0585633517**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46861**	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 : HEARTBURN EPIGASTRIC PAIN ,FEVER HOPC : PT CAME WITH THE COMPLAIN OF EPIGASTRIC PAIN NAUSEA ALONG WITH THE HEART BURN AND GASEOUS STOMACH DISTENSION ALSO COMPLAIN OF LEFT HAND ELBOW PAIN O/E DISTENDED STOMACH DUE TO GASES ALLERGIES NONE PMH: hyperglycemia ,htn			

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 : 120 : 18	T : 36.6	HR : 72	RR

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R73.9	Hyperglycemia, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	R05	Cough
Secondary	M25.521	Pain in right elbow
Secondary	R50.9	Fever, unspecified
Secondary	R12	Heartburn
Secondary	R11.0	Nausea
Secondary	R14.3	Flatulence

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:		

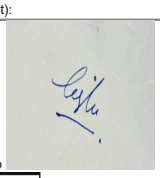
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
9	GP Consultation	General Consultation	25.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000

CPT Code	Treatment	Type	Price
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-174202-0781	RISEK 40MG	Pharmacy	34.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000

Code	Generic	Duration	Instructions
0435-189401-1112	(CALCIUM CARBONATE : N/A) (SODIUM BICARBONATE : N/A) (SODIUM ALGINATE : N/A) SUSPENSION	30	Take 1Syrup 1Time(s) perDay For 30 Day(s) others
1516-151709-0081	(SIMETHICONE : 42 MG) CHEWABLE TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others
0837-277601-1161	(OXOMEMAZINE : 0.33 MG/ML) SYRUP	1	Take 1Syrup 1Time(s) perDay For 1 Day(s) others
2093-596002-0431	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	1	Take 1Gel 1Time(s) perDay For 1 Day(s) others
0207-379203-1171	(AMLODIPINE (AS BESYLATE) : 5MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0321-164103-2191	(METFORMIN HCL : 500 MG) PROLONGED RELEASE TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

○ 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 : **AISHA**		
Tel / Fax (important):		
Signature & Stamp  Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 30-Jul-2025	
Note: Claims must be submited along with supportng documents within 30 days from date of service		