

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MOHAMAD HASAN ABDULMAJED	Gender:	Male	Validity Between:	23/03/2025 and 22/03/2026
Card No:	B044-57B0-734A-7FB8	DOB:	1/1/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-6296296-5	Service Date:	31-Jul-2025	Radiology:	Covered
		Patent's Tel No:	0505579398		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43881	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 : LOW BLOOD PRESSURE AND FOOT PAIN HOPC : PT CAME WITH THE COMPLAIN OF WEAKNESS ALONG WITH LEFT FOOT PAIN STARTED TWO DAYS BACK HE FEELS WEAK ALLERGIES NONE PMH : NONE						
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 : 100 T : 36.2 HR : 80 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	I95.9	Hypotension, unspecified			
Secondary	R52	Pain, unspecified			
Secondary	D51.3	Other dietary vitamin B12 deficiency anemia			
Secondary	E86.0	Dehydration			
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:		

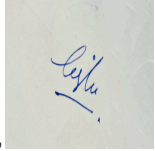
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
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
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0384-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000

Code	Generic	Duration	Instructions
5254-830602-2401	(VITAMIN B1 (THIAMINE) : 100 MG) (VITAMIN B6 (AS PYRIDOXINE HCL) : 200 MG) (VITAMIN B12 (CYANOCOBALAMIN) : 200 MCG) SUGAR COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0077-258502-1171	(SODIUM AISCINATE : 20 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others

Code	Generic	Duration	Instructions
2027-719101-0392	(PARACETAMOL : 500 MG) (IBUPROFEN : 150 MG) (PHENYLEPHRINE HCL : 2.5 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 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> <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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
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 : 31-Jul-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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