

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AZHARUDDIN MOHAMMAD MOHAMMAD MASIUDDIN	Gender:	Male	Validity Between:	01/03/2025 and 28/02/2026
Card No:	B32E-FB03-AC97-6FBB	DOB:	4/15/1986 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1986-5827542-9	Service Date:	04-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0554780238		
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:	47542	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint PC fever,chills,weakness,runny nose HOPC pt presented with complaints of fever with chills,bodypain,weakness and running nose since 3 days O\e Chest clear He looks pale and tired No history of drug allergy Previous history of hyperlipidemia present						DD	MM	YYYY
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 : 37.7		HR : 98		RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	E78.5	Hyperlipidemia, unspecified									
Secondary	R50.9	Fever, unspecified									
Secondary	R52	Pain, unspecified									
Secondary	R53.81	Other malaise									

Type	Code	Diagnosis
Secondary	J06.9	Acute upper respiratory infection, 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
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0384-207801-1002	LACTATED RINGERS & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FOR INFUSION (500ML, BOTTLE)	Pharmacy	5.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
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

Code	Generic	Duration	Instructions
0248-106304-0271	(ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0013-127405-0391	(AZITHROMYCIN : 500 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 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 benefsts. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : KEERTHANA		
Tel / Fax (important):		

Signature & Stamp د. كيرثانا راني باديپورايل 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 : 04-Aug-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 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 efects 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.