eASOAP FORM

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

Patent Name:	**MEREYIM BOUSLIKHANE**	Gender:	**Female**	Validity Between:	**15/03/2025 and 14/03/2026**
Card No:	**2B92-525E-1CBB-458F**	DOB:	**7/9/1974 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1974-2574285-1**	Service Date:	**07-Aug-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0509450399**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47558**	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 generalised itching over upper and lower limb,chest,edema both leg and hand HOPC generalised itching and rashes over the upper limb,lower limb and trunk since 5days associated with edema of both hands and pedal edema She also has periorbital edema and itching O\E generalised petechial rashes over upper limb,lower limb,trunk and chest non pitting pedal edema and hand edema present She has pain during urination No history of drug allergy			

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 T : 37 HR : 82 RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	D69.0	Allergic purpura

Type	Code	Diagnosis
Secondary	L29.8	Other pruritus
Secondary	R60.0	Localized edema
Secondary	R30.0	Dysuria
Secondary	R80.0	Isolated proteinuria

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:		

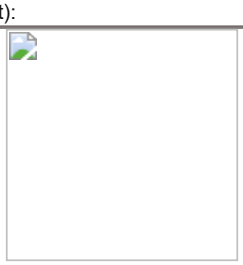
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
86140	C-reactive protein;	Lab	15.0000

Code	Generic	Duration	Instructions
0085-227402-0372	(NAPHAZOLINE : 0.025%) (PHENIRAMINE MALEATE : 0.3%) EYE DROPS	5	Take 1Drops 2 Time(s) per Day For 5 Day(s) others
8091-058801-0571	(CALAMINE : 10%) (VITAMIN E : 0.5%) (ALLANTOIN : 0.5%) (ALOE VERA : 10.5%) LOTION	10	Take 1Lotion 2 Time(s) per Day For 10 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
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 2Tablets 2 Time(s) per Day For 5 Day(s) others

○ 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 : **KEERTHANA**	
Tel / Fax (important):	
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 

Date :	Date : 07-Aug-2025
Note: Claims must be submited 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 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.