

# eASOAP FORM



## ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

|                   |                                      |                   |                             |                          |                                       |
|-------------------|--------------------------------------|-------------------|-----------------------------|--------------------------|---------------------------------------|
| Patent Name:      | <b>AYESHA YASEEN KHAIL UR REHMAN</b> | Gender:           | <b>Female</b>               | Validity Between:        | <b>15/05/2025 and 14/05/2026</b>      |
| Card No:          | <b>ABD1-B01F-3CBA-E855</b>           | DOB:              | <b>6/5/1992 12:00:00 AM</b> | Coverage Informaton for: | <b>Out Patient</b>                    |
| Pin #:            |                                      | Identty Card:     |                             | Network:                 | <b>RN UAE (Al Ansari-AUH)-MEDGULF</b> |
| Natonal ID:       | <b>784-1992-5098633-0</b>            | Service Date:     | <b>09-Aug-2025</b>          | Radiology:               | <b>Covered</b>                        |
| Policy Holder:    |                                      | Patent's Tel No:  | <b>555298400</b>            |                          |                                       |
|                   |                                      | Threshold Limit:  |                             |                          |                                       |
| Payer Name:       | <b>ORIENT INSURANCE P.J.S.C</b>      | Class:            | <b>Normal</b>               |                          |                                       |
|                   |                                      | Out-Patent :      |                             |                          |                                       |
| Category:         | <b>Category B</b>                    | Patent's File No: | <b>41881</b>                | Pharmacy:                | <b>Co-Part: 20%</b>                   |
| Gatekeeper:       | <b>No</b>                            | Consultaton :     |                             | Laboratory:              | <b>Covered</b>                        |
| Referral No:      |                                      |                   |                             |                          |                                       |
| Referred Service: |                                      |                   |                             |                          |                                       |

## SUBJECTIVE ASSESSMENT

| Symptom(s) as described by the patent (Chief Complaint):                                                                                                                |                                   |                              |      |                           |                          | Date of Symptoms/illness started |    |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------|------|---------------------------|--------------------------|----------------------------------|----|------|
| <b>Complaint</b><br>pc :<br>ten times unilateral kind of headache. ASSOCIATED WITH DIZINESS , NAUSEA , AND FLICERING OF LIGHTS<br><br>o/e : look irritable<br>LETHARGIC |                                   |                              |      |                           |                          | DD                               | MM | YYYY |
|                                                                                                                                                                         |                                   |                              |      |                           |                          |                                  |    |      |
| Past Medical Surgical History?                                                                                                                                          |                                   |                              |      | <input type="radio"/> Yes | <input type="radio"/> No | Date of Symptoms/illness started |    |      |
|                                                                                                                                                                         |                                   |                              |      |                           |                          | DD                               | MM | YYYY |
|                                                                                                                                                                         |                                   |                              |      |                           |                          |                                  |    |      |
| Obs/Gyn Claims                                                                                                                                                          |                                   |                              |      |                           |                          | Date of Symptoms/illness started |    |      |
|                                                                                                                                                                         |                                   |                              |      |                           |                          | DD                               | MM | YYYY |
| <input type="checkbox"/> Para                                                                                                                                           | <input type="checkbox"/> Gravida: | <input type="checkbox"/> 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? <input type="radio"/> Yes <input type="radio"/> No if yes, indicate what Assessment and since when:                         |                                   |                              |      |                           |                          |                                  |    |      |

## OBJECTIVE / ASSESSMENT (To be completed by Physician)

|                     |                         |          |         |    |
|---------------------|-------------------------|----------|---------|----|
| Clinical Findings : | Vital Signs : B/P : 140 | T : 36.2 | HR : 78 | RR |
|                     | : 22                    |          |         |    |

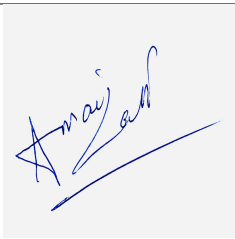
| Assessment/Diagnosis : <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Confirmed <input type="radio"/> Suspected<br>INDICATE DIAGNOSIS NOT SYMPTOM |        |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------------|
| Type                                                                                                                                                                               | Code   | Diagnosis                         |
| Primary                                                                                                                                                                            | R51.9  | Headache, unspecified             |
| Secondary                                                                                                                                                                          | R11.2  | Nausea with vomiting, unspecified |
| Secondary                                                                                                                                                                          | K29.00 | Acute gastritis without bleeding  |
| Secondary                                                                                                                                                                          | H57.13 | Ocular pain, bilateral            |

| 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: |
| <input type="radio"/> Yes <input type="radio"/> No                                                                | <input type="radio"/> Yes <input type="radio"/> 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                                             |
| 5314-199803-1171                                                                                                            | (SUMATRIPTAN : 100 MG) TABLETS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 15                   | Take 1Tablets 1 Time(s) per Day For 15 Day(s) after meal |
| 0188-130103-0392                                                                                                            | (PROPRANOLOL HCL : 10 MG) FILM COATED TABLETS                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10                   | Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal |
| 2654-636101-0061                                                                                                            | (STARFLOWER OIL : 100 MG) (EVENING PRIMROSE OIL : 100 MG) (VITAMIN D3 : 5 MCG) (VITAMIN E : 30 MG) (VITAMIN C : 60 MG) (THIAMINE (VITAMIN B1) : 10 MG) (RIBOFLAVINE (VITAMIN B2) : 5 MG) (NIACIN : 36 MG) (VITAMIN B6 : 10 MG) (FOLACIN : 400 MCG) (VITAMIN B12 : 20 MCG) (BIOTIN : 50 MCG) (PANTOTHENIC ACID : 6 MG) (VITAMIN K : 90 MCG) (NATURAL MIXED CAROTENOIDS : 2 MG) (IRON : 12 MG) (MAGNESIUM : 100 MG) (ZINC : 12 MG) (MANGANESE : 2.5 MG) (COPPER : 1.5 MG) (SELENIUM : 100 MCG) (CHROMIUM : 50 MCG) (PA | 30                   | Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal |
| 2104-379202-1451                                                                                                            | (AMLODIPINE (AS BESYLATE) : 10 MG) CAPSULES (HARD GELATIN)                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10                   | Take 1Tablets 1 Time(s) per Day For 10 Day(s) others     |

|                                 |                                      |                                               |                 |
|---------------------------------|--------------------------------------|-----------------------------------------------|-----------------|
| <input type="radio"/> Pharmacy: | Estimated Costs                      | <input type="radio"/> Laboratory / Radiology: | Estimated Costs |
| Is the following required       | <input type="radio"/> Surgery:       | <input type="radio"/> Endoscopy:              |                 |
|                                 | <input type="radio"/> Physiotherapy: | <input type="radio"/> Other Procedures:       |                 |
|                                 | If yes please specify                |                                               |                 |

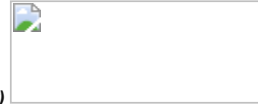
| Is In-patient Required ? Length of Stay                                                                                                                                       | Indicate Provider                                                                                                                                                                                                                                                                             | 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 benefets. Medical management is the sole responsibility of doctor and the patent. |               |
| Treating Physician Name : DR Amaizah                                                                                                                                          |                                                                                                                                                                                                                                                                                               |               |
| Tel / Fax (important):                                                                                                                                                        |                                                                                                                                                                                                                                                                                               |               |



Signature & Stamp

**Dr. Amaizah Ishtiaq**  
General Practitioner  
DHA: 98486553-001  
CITICARE MEDICAL CENTER  
DUBAI - U.A.E

**Patient's Signature(Parent if minor)**



Date :

Date : 09-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 creation 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 final opinion will be given by the NEXtCARE claims doctors.