

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	AYESHA YASEEN KHAIL UR REHMAN	Gender:	Female	Validity Between:	15/05/2025 and 14/05/2026
Card No:	ABD1-B01F-3CBA-E855	DOB:	6/5/1992 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1992-5098633-0	Service Date:	09-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	555298400		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41881	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 pc : ten times unilateral kind of headache. ASSOCIATED WITH DIZINESS , NAUSEA , AND FLICERING OF LIGHTS o/e : look irritable LETHARGIC						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 : 130 : 22	T : 36.2	HR : 78	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
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:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

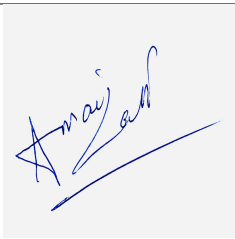
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000

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

☐ 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 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.