

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	SAMAN KUMARA JAYAWADHANA JAYAWARDHANA MUDIYANSELAG	Gender:	Male	Validity Between:	07/12/2024 and 06/12/2025
Card No:	2E34-D3BB-F7C5-887A	DOB:	9/23/1985 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1985-0730281-2	Service Date:	09-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0559206399		
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:	47576	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

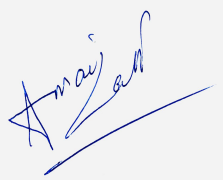
Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint					DD	MM	YYYY
PC : SEVRE PAIN IN EAR CANAL AND NECK LEFT SIDE ASSOCIATED WITH LOW GRADE FEVER							
NECK STIFFNESS NOT ABLE TO OPEN MOURTH DUE TO PAIN CAUSED BY CYSTIC SWELLING							
Past Medical 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 : 120 T : 36.8 HR : 70 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R21	Rash and other nonspecific skin eruption					
Secondary	H60.12	Cellulitis of left external ear					
Secondary	R52	Pain, unspecified					
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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
Code	Generic	Duration	Instructions
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal
0195-187502-0151	(BETAMETHASONE : 0.10%) (FUSIDIC ACID : 2%) CREAM	5	Take 1Cream 1 Time(s) per Day For 5 Day(s) others
0027-149903-0111	(DICLOFENAC SODIUM : 100 MG) COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
☐ Pharmacy:		Estimated Costs	
☐ Laboratory / Radiology:		Estimated Costs	
☐ Surgery:		☐ Endoscopy:	
☐ Physiotherapy:		☐ Other Procedures:	
Is the following required		If yes please specify	

Is In-patient Required ? Length of Stay		Indicate Provider		Estimate Cost	
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 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					

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