

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: ATIQR RAHMAN	Gender: Male	Validity Between: 01/11/2024 and 31/10/2025
Card No: 9A1A-3726-D980-3893	DOB: 7/20/1982 12:00:00 AM	Coverage Information for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1982-0354298-4	Service Date: 15-Aug-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0568798553	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent :	
Gatekeeper: No	Patent's File No: 43018	Pharmacy: Co-Part: 20%
Referral No:	Consultaton :	Laboratory: Covered
Referred Service:		

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):		Date of Symptoms/illness started		
Complaint		DD	MM	YYYY
pc : shortness of breath and palpitations and chest tightness started 10/08/25 loss of appetite and bloating started 02 /08/25 known diabetic and know htn o/e : look pale and lethrgic tachycardia				
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 : 137 T : 36.4 HR : 97 RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected		
INDICATE DIAGNOSIS NOT SYMPTOM		
Type	Code	Diagnosis
Primary	E11.9	Type 2 diabetes mellitus without complications
Secondary	R00.2	Palpitations
Secondary	R06.02	Shortness of breath

Type	Code	Diagnosis
Secondary	D50.9	Iron deficiency anemia, unspecified
Secondary	J06.9	Acute upper respiratory infection, unspecified
Secondary	E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
Secondary	R14.3	Flatulence

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
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
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

Code	Generic	Duration	Instructions
1267-141614-1112	(ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION	7	Take 15ML 2 Time(s) per Day For 7 Day(s) after meal
5254-035101-2401	(PYRIDOXINE HYDROCHLORIDE : 200 MG) (CYANOCOBALAMIN : 200 MCG) (THIAMINE : 100 MG) SUGAR COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
0252-182201-0081	(FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal

☐ 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>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>		<i>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 benefits. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : DR Amaizah		
Tel / Fax (important):		
 Signature & Stamp		 Patient's Signature(Parent if minor)
		
Date :	Date : 15-Aug-2025	
Note: Claims must be submitted along with supportng documents within 30 days from date of service		

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