

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MOHAMMED HUDAN AHAMED HOSSAIN	Gender:	Male	Validity Between:	01/08/2025 and 31/07/2026
Card No:	4F55-22BC-7D1E-E6D7	DOB:	12/10/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1978-3632171-7	Service Date:	18-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0551138109		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	34675	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 HX OF LIFTING HEAVY OBJECT , PAIN IS SEVERE WHICH IS 08 ON PAIN SCORE FEVER WHICH IS HIGH GRADE 38 O/E HYPEREMIC PHARYNX O/E : TENDR LOW BACK						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 : 120 T : 38 HR : 70 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	R50.9	Fever, unspecified			

Type	Code	Diagnosis
Secondary	J02.9	Acute pharyngitis, unspecified
Secondary	R21	Rash and other nonspecific skin eruption
Secondary	G89.11	Acute pain due to trauma

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

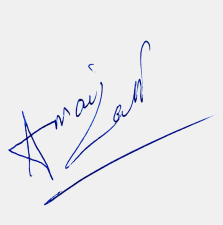
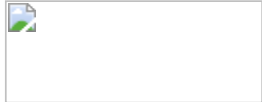
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9.01	Follow-up consultation	General Consultation	0.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000

Code	Generic	Duration	Instructions
3819-373201-0391	(TOLPERISONE HCL : 150 MG) FILM COATED TABLETS	3	Take 1Tablets 1 Time(s) per Day For 3 Day(s) after meal
0027-142201-0832	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 1sachet 1 Time(s) per Day For 5 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 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>		<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 : 18-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 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 effects caused due to the claims submissions. NEXtCare assumes no

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