

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	Francisco Don Aguilar	Gender:	Male	Validity Between:	01/11/2024 and 31/10/2025
Card No:	0840-38CA-DCA8-D7DF	DOB:	9/9/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-2481071-6	Service Date:	18-Aug-2025	Radiology:	Covered
		Patent's Tel No:	0582631050		
Policy Holder:		Threshold Limit:			
Payer Name:	UNITED INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	46582	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					DD	MM	YYYY
PC : 6 EPISODES OF VOMITING , AND LOOSE STOOL STARTED 19/08/25							
ASSOCIATED WITH PAIN IN ABDOMEN AND BLOATED							
O/E : ELEVATED BP							
TENDER ABDOMEN							
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 : 160 T : 36.8 HR : 80 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	R19.7	Diarrhea, unspecified	
Secondary	R11.11	Vomiting without nausea	
Secondary	A09	Infectious gastroenteritis and colitis, unspecified	
Secondary	E78.5	Hyperlipidemia, unspecified	

Type	Code	Diagnosis
Secondary	I10	Essential (primary) hypertension

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
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
9	GP Consultation	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000

Code	Generic	Duration	Instructions
6619-608703-0831	(SODIUM CHLORIDE : 0.52 G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CITRATE : 0.58 G) (GLUCOSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	2	Take 1Tablets 1 Time(s) per Day For 2 Day(s) others
0207-379203-1171	(AMLODIPINE (AS BESYLATE) : 5MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) after meal
0252-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) before meal
0152-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal

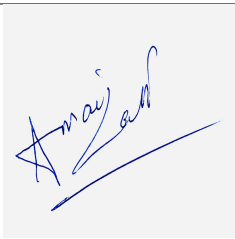
☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
	If yes please specify		

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

I 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 benefsts. Medical management is the sole responsibility of doctor and the patent.

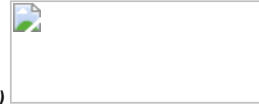
Treating Physician Name : DR Amaizah	
Tel / Fax (important):	



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 : 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 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.