

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MUHAMMAD FARHAN SHAHID	Gender:	Male	Validity Between:	12/12/2024 and 11/12/2025
Card No:	3547-3D41-18DE-25B5	DOB:	2/23/1996 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1996-3749435-4	Service Date:	21-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0567175507		
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:	42497	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

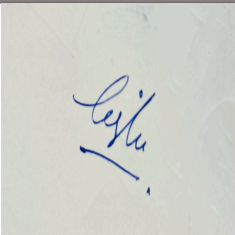
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC : LOCAL ABSCESS AT THE BUTTOCK PT CAME WITH THE COMPLAIN OF SMALL WOUND AT THE MIDDLE OF BUTTOCKS STARTED TWO WEEKS AGO IN THE BEGINNING IT WAS INFLAMMED AND BUS THERE TODAY WHEN HE VISITED ITS COMPLETELY DRY AND NO SIGN OF INFLAMMATION								
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 : 36.6 HR : 70 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	S31.809A	Unspecified open wound of unspecified buttock, init encntr					
Secondary	R52	Pain, unspecified					
Secondary	E86.0	Dehydration					
Secondary	R09.81	Nasal congestion					

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
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0384-111908-1001	SODIUM CHLORIDE BP	Pharmacy	4.5000
86140	C-reactive protein;	Lab	15.0000
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
2733-646901-3851	(IPRATROPIUM BROMIDE MONOHYDRATE : 0.6 MG/ML) (XYLOMETAZOLINE HCL : 0.5 MG/ML) NASAL SPRAY	5	Take 1Spray 2 Time(s) per Day For 5 Day(s) others
0281-187603-0152	(FUSIDIC ACID : 20 MG/G) (HYDROCORTISONE ACETATE : 10 MG/G) CREAM	5	Take 1Ointment 2 Time(s) per Day For 5 Day(s) others
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:
			Estimated Costs
Is the following required		☐ Surgery:	
		☐ Endoscopy:	
		☐ Physiotherapy:	
		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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : AISHA		
Tel / Fax (important):		
 Signature & Stamp Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E	Patient's Signature(Parent if minor)	
Date :		
Date : 21-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 efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.