

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	HAREEM AKHTAR MALIK PERVEZ AKHTAR	Gender:	Female	Validity Between:	02/07/2025 and 21/12/2025
Card No:	EDA9-96E7-BC3B-71B1	DOB:	1/31/2001 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-2001-6605592-9	Service Date:	23-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0563949253		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	47689	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 PC SHIVERING,BREATHING DIFFICULTY,TIREDNESS,CHEST PAIN HOPC PT PRESENTS WITH COMPLAINTS OF SUDDEN ONSET SHIVERING,BREATHING DIFFICULTY,CHEST PAIN,TIREDNESS THAAT STARTED AT AROUND 1.30AM Pt had similar episode 5 months back She denies any food allergy O\E she looks pale,irritated SpO2 99% Chest clear Pulse regular Conscious oriented She had chicken curry for the dinner at around 8 pm						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 : 140 : 20	T : 36.6	HR : 88	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM		
Type	Code	Diagnosis
Primary	R68.83	Chills (without fever)
Secondary	R06.00	Dyspnea, unspecified
Secondary	R25.1	Tremor, unspecified
Secondary	R11.0	Nausea
Secondary	R07.9	Chest pain, unspecified

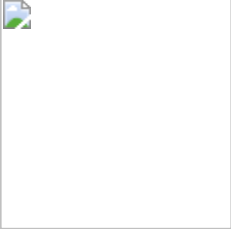
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000
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
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400

Code	Generic	Duration	Instructions
No Prescriptions History Found			

☐ 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 mentioned 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 : KEERTHANA		
Tel / Fax (important):		
Signature & Stamp  		
Date :	Date : 23-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.