eASOAP FORM



ADMINISTRATIVE The member is allowed for **Out Patient** at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	JUGRAJ BOTHRA	Gender:	Male	Validity Between:	27/12/2024 and 26/12/2025
Card No:	37C8-2ECB-680E-AF04	DOB:	1/15/1938 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1938-5462724-2	Service Date: Patent's Tel No:	23-Aug-2025 0561211405	Radiology:	Covered
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42962	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred					
Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) a	s described by	y the pat	tent (Chie	f Complaint)	:				Date of S	ymptoms/illi	ness started		
Complaint									DD	MM	YYYY		
chief compla	in: cough with	n sputun	n, yellowi	sh sputum si	nce some da	ys.							
also have hy	pertension												
on examinat	ion: chest con	gestion.											
no fever													
medicine allergy: nil													
Past Medical S	Surgical Histor	v?			○Yes		O No		Date of S				
- ast meaned		· ·			0 103		0 140		Date of Symptoms/illness DD MM YYYY Date of Symptoms/illness DD MM YYYY Pen: T: 36.2 HR: 84	YYYY			
Obs/Gyn Clain	ns												
Para	Gravida:		AB:	LMP:	Marital Statu		Marital Date:		טט	IVIIVI	1111		
□ Para	Gravida:		□ АВ:	LIVIP:	Marital Statu	15.	Iviantal Date:						
What date did t	he Patient first	feel sam	ne / similar	Symptom(s)	: dd mm yyy	у							
ls the Patient u	nder any type o	of Treatm	nent? O	Yes O No	if yes, indica	te what Asse	ssment and since	when:					
OBJECTIVE / A	SSESSMENT	(To be co	ompleted b	y Physician)									
Clinical Findings : Vital Signs : B/P : 130 T : 36.2 : 18								6.2	HR : 84	RR			
Assessment/D INI	iagnosis : DICATE DIAG	O Acu NOSIS N		Chronic PTOM	O Confirme	ed OSusi	pected						
Туре		Code		Diagnosis									
Primary		I10		Essential (pr	imary) hyper	tension							
Secondary		R05		Cough									
Secondary		J22		Unspecified	nspecified acute lower respiratory infection								
ACCIDENT/OC	CUPATIONAL	Claim In	nformator	n (complete i	if claim is a r	esult of accid	lent or work relat	ed illne	ss/iniury	·)			

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 Duration Take 1Tablets 1 Time(s) per Day For 60 Day(s) others 0042-220701- 1171 (TELMISARTAN: 40 MG) TABLETS 60 Take 1Tablets 1 Time(s) per Day For 60 Day(s) others 0027-265802- 0027-265802- 1161 (BUTAMIRATE DIHYDROGEN CITRATE: 0.15% W/V) SYRUP 5 Take 10ML 3 Time(s) per Day For 5 Day(s) others 1171 (TELMISARTAN: 20 MG) TABLETS 30 Take 1 Unit(s), 1 Time(s) per Day For 5 Day(s) others 1171 (TELMISARTAN: 20 MG) TABLETS 30 Take 1 Unit(s), 1 Time(s) per Day For 5 Day(s) others 1171 SI In-patient Required S Surgery: Estmated Costs Surgery: Endoscopy: Physiotherapy: Other Procedures: If yes please specify Indicate Provider Increase any Information mentioned are correct and the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Dr. Farhan lyas Tel / Fax (important):				Injury due accident?	to road	Describe how the accident or work related injury/illness occur:					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim PT Code Treatment GP Consultation Instructions GP Consultation GP Consultation Instructions Instructions Instructions Instructions Instructions Instructions Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) per Day For 5 Day(s) others Take 10Alt 3 Time(s) p	○ Yes ○ No			○Yes ○	No						
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attention of the purpose of the management of the this case. Treating Physician Name : Dr. Farhan Iyas To the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp Dr. Fahan Ilyas Malik Physidan-General Practitioner DDHA-06441782-001 CITICARE MEDICAL CENTER DUBAIU.A.E Date: 39 Aug-2025 Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s) To the pay For 30 Day(s) Stanted Costs Laboratory / Radiology: Estmated Costs I fundscapper: If yes please specify In fereby authorize any Healthcree Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp Dr. Frahan Ilyas Malik Physidan-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAIU.A.E Date: 23-Aug-2025	III			(CLAVULAN	IC ACID : 12	5 MG) FILM	5				
Day(s) Day(s) Estmated Costs Caboratory / Radiology: Estmated Costs		(BUTAMIRATE	DIHYDROG	SEN CITRATE	: 0.15% W/	V) SYRUP	5				
Surgery: Endoscopy:		220703- (TELMISARTAN : 20 MG) TABLETS							nit(s), 1 Time(s) per Day For 30		
Is the following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Estimate Cost I hereby certfy that all information mentioned are correct that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Dr.Farhan lyas Tel / Fax (important): Signature & Stamp Dr. Frahan lyas Malik Physician-General Practitioner DHA-06441782-001 CITICARE MEDICAL CENTER DUBAI U.A.E Patient's Signature(Parent if minor) Date: 23-Aug-2025	O Pharmacy:		Estmated	Costs		O Laborato	.aboratory / Radiology:			Estmated Costs	
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If yes please specify Is In-patient Required? Length of Stay Indicate Provider Indicat											
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Note: Claims must be submitted along with supporting decuments within 20 decentions date of semiles											

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 final opinion will be given by the NEXtCARE claims doctors.