

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: ABEL SIMON VAN IGHEM	Gender: Male	Validity Between: 21/07/2025 and 20/07/2026
Card No: 6551-D847-F77E-2A91	DOB: 5/7/1991 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1991-1804439-7	Service Date: 24-Aug-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0527044418	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
Category: Category B	Out-Patent : Patent's File No: 44550	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 : SEVRE CHEST TIGHTNESS, SEVRE HEDACHE , COUGH WHICH IS DRY , AND SNEZING AND RUNNY NOSE AND ALSO HIGH GRDAE FEVER STARTED 23/08/25 O/E : LOOK IRRITABLE , DEHYDRATED TEMP 37.6 HYPERMIC PHARYNX WTH HYPEREMIA OF PILLAR TONSILS ARE COVERED WITH WHITE FOLICLES FOLLICULAR TIONSILITIS CHEST WHEEZING				
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 T : 37.6 HR : 90 RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM	

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified
Secondary	R06.2	Wheezing
Secondary	R09.81	Nasal congestion
Secondary	R50.9	Fever, unspecified
Secondary	R51.9	Headache, unspecified
Secondary	R05	Cough
Secondary	J03.00	Acute streptococcal tonsillitis, 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:		

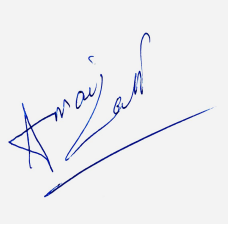
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	Pharmacy	8.4000
86140	C-reactive protein;	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 15ML 2 Time(s) per Day For 7 Day(s) after meal
2027-560101-0391	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening
0397-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 certify that all informaton mentoned are correct & that the medical services shown on this form were		I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE

medically indicated & necessary for the management of this case.	for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.
Treating Physician Name : DR Amaizah	
Tel / Fax (important):	
 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 24-Aug-2025
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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