

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	RHEA LETIZIA JAIRIN	Gender:	Female	Validity Between:	13/06/2025 and 12/06/2026
Card No:	9B1E-3D3F-96FB-25F0	DOB:	7/9/2023 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2023-1168470-2	Service Date:	25-Aug-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0556811094		
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:	47136	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
2 years old girl with C/O: cough runny nose, flu , congestion fever duration: 5 days taking cefpodoxime since 3 days. vaccinated for her age brother is also having similar complaints of viral fever ongoing. birth normal, developmentally appropriate for her age Picky eater, fusses around food. on examination: hyperemic and congested throat with enlarged tonsillar pillars pale conjunctiva , pallor on hands, height and weight are on less than 5th percentile > needs evaluation of nutritional deficiencies. CNS: Intact CVS: Heart sounds normak chest: harsh vesicular breathing Abdomen: soft, non tender			
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 : 0	T : 37.1	HR : 102	RR
				: 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J30.9	Allergic rhinitis, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	E56.9	Vitamin deficiency, unspecified					
Secondary	D64.9	Anemia, 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:		

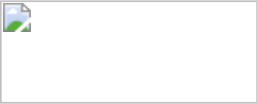
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
82728	Ferritin	Lab	20.0000
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Lab	100.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
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
0006-106607-1161	(PARACETAMOL : 240 MG/5ML) SYRUP	3	Take 3ML 2 Time(s) per Day For 3 Day(s) after meal, in case of fever
6396-925801-3851	(SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY	5	Take 3ML 4 Time(s) per Day For 5 Day(s) before meal
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	5	Take 5 Unit(s), 1 Time(s) per Day For 5 Day(s)

☐ 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 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Dr Bushra		
Tel / Fax (important):		

 <i>Signature & Stamp</i> Dr. Bushra Mutfi General practitioner DHA: 75646242-001 CITICARE MEDICAL CENTER DUBAI - U.A.E	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 25-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.