

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	JAIDEN EMMANUEL JAIRIN GIFT	Gender:	Male	Validity Between:	13/06/2025 and 12/06/2026
Card No:	4532-5E56-59BE-E4A7	DOB:	12/23/2020 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2020-1772057-8	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:	47135	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		
5 years old boy with C/O: cough runny nose, flu , congestion fever duration: 3 days vaccinated for his age sister is also having similar complaints of viral fever ongoing. birth normal, developmentally appropriate for age Picky eater, fusses around food. both siblings not having appropriate appetite. on examination: hyperemic and congested throat with enlarged tonsillar pillars pale conjunctiva , pallor on hands, height on 25th centile and weight is 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 : 36.8		HR : 89		RR	
			: 18								
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:		

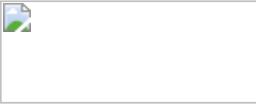
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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
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
6396-925801-3851	(SEA WATER (SODIUM CHLORIDE) : 0.9% (28 ML / 100 ML)) NASAL SPRAY	3	Take 3ML 2 Time(s) per Day For 3 Day(s) before meal
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	5	Take 5ML 1 Time(s) per Day For 5 Day(s) evening

☐ 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 benefsts. 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.