eASOAP FORM

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

Patent Name:	**NATALIA VERENIKINA**	Gender:	**Female**	Validity Between:	**29/11/2023 and 28/11/2024**
Card No:	**9DB4-7E26-4F98-D3EC**	DOB:	**1/8/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-4649204-4**	Service Date:	**29-Jul-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0566884536**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43457**	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
No Complaints Found for Selected Appointment					
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 : 111	T : 36	HR : 84	RR : 18

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	N93.9	Abnormal uterine and vaginal bleeding, 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
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
10	Specialist Consultation	General Consultation	45.0000
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Radiology	80.0000
76700	Ultrasound, abdominal, real time with image documentation; complete	Radiology	120.0000
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053), Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004), OR, Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009), Thyroid stimulating hormone (TSH) (84443)	Lab	85.0000
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)	Lab	25.0000
86703	Antibody; HIV-1 and HIV-2, single result	Lab	25.0000

Code	Generic	Duration	Instructions
2850-116604-1102	(METRONIDAZOLE : 500 MG) SUPPOSITORY	7	Take 1Suppository 1 Time(s) per Day For 7 Day(s) others
5447-299908-2741	(CLINDAMYCIN (AS PHOSPHATE) : 100 MG) VAGINAL SUPPOSITORIES	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
L83-1920-03780-01	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
0248-140201-0061	(FLUCONAZOLE : 150 MG) CAPSULES	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 certfy 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 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **MOHAMMED M HAMED**		
Tel / Fax (important):		
Signature & Stamp  	*Patient's Signature(Parent if minor)* 	
Date :	Date : 29-Jul-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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 fnal opinion will be given by the NEXtCARE claims doctors.