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:	**09-Aug-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**		
	DD	MM	YYYY
Complaint PATIENT HAS ABNOEMAL UTERINE BLEEDING WITH PAP SMEAR AND COLPOSCOPY BIOPSY RESULTS INDICATING HIGH GRADE LESION WHICH IS PRECANCEROUS SHE IS IN-NEED OF ULTRASOUND AND AT LEAST URINEANALYSIS AND STDS SCREENING IF THE INSURANCE WILL REJECT THIS YOU CAN SEND US AN EMAIL OR REPORT TO FORWARD IT TO THE PATIENT IN ORDER TO CLEAR OUR RESPONSIBILTY THANKS FOR CO-OPERATION			
painful when urinating with blood since 1 week Aug 2 2024. Lower abdominal pain 1 week Aug 2 2024. Vaginal discharge that is an unusual color or consistency 1 week Aug 2 2024. Genital rash or redness & Itching			

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 : T : HR : RR :

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	N93.9	Abnormal uterine and vaginal bleeding, unspecified
Secondary	E03.9	Hypothyroidism, unspecified
Secondary	N76.0	Acute vaginitis
Secondary	N39.0	Urinary tract infection, site not specified
Secondary	R87.619	Unsp abnormal cytolog findings in specmn from cervix uteri

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
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	Lab	30.0000
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates	Lab	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
76700	Ultrasound, abdominal, real time with image documentation; complete	Radiology	120.0000
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
No Prescriptions History Found			

○ 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 : 09-Aug-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.