eASOAP FORM

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

Patent Name:	**ZAYNAH ZAHID OMER ZAHID SATTAR OMER**	Gender:	**Female**	Validity Between:	**22/07/2024 and 21/07/2025**
Card No:	**6A09-EBBB-FB44-A763**	DOB:	**12/24/1999 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1999-1748010-7**	Service Date:	**14-Aug-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502644864**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40951**	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 PC: Recurrent headaches, Headache is present almost every days of the week but has never been so intense. Now scored: 9/10, as against previous episodes of 6/10. It is located bilaterally, on the temporal side of both eyes, throbbing, nagging, associated with nausea and anger and often present in the mornings upon waking up from sleep. There is no fever, no vomiting, no blurring of vision, but uses corrective lenses for distant vision (short sighted). Not hypertensive and not diabetic, and has no other chronic medical condition. Menstruates for 10 - 12 days and LMP = 1/08/2024. Patient is couinselled to see Gynecologist and ophthalmologist.			

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 : 105 T : 377 HR : 87 RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R51.9	Headache, unspecified
Secondary	G43.119	Migraine with aura, intractable, without status migrainosus
Secondary	N92.0	Excessive and frequent menstruation with regular cycle
Secondary	E03.9	Hypothyroidism, unspecified
Secondary	E55.9	Vitamin D deficiency, unspecified
Secondary	K29.70	Gastritis, unspecified, without bleeding

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
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
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
9	GP Consultation	General Consultation	25.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
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
0444-348905-0971	(CHOLECALCIFEROL : 10000 IU) SOFT GELATIN CAPSULES	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening
0137-242801-0341	(PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
1395-397601-0391	(SUMATRIPTAN (AS SUCCINATE) : 100 MG) FILM COATED TABLETS	2	Take 1Tablets 1 Time(s) per Day For 2 Day(s) evening
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	12	Take 1Tablets 2 Time(s) per Day For 12 Day(s) after meal

○ 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 : **Enomen Goodluck**		
Tel / Fax (important):		

Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 14-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.