eASOAP FORM

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

Patent Name:	**SHAKKIRA ABOOBACKER**	Gender:	**Female**	Validity Between:	**27/10/2023 and 26/10/2024**
Card No:	**1233-4308-3A33-EF38**	DOB:	**8/24/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:	**542806**	Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-8960304-3**	Service Date:	**06-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0565542806**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40368**	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			
she need to continue the injection through out			
by abdominal ultrasound examination there is evidence of gravid uterus with good endometrial thickness and good decidual reaction the patient is in need of Clexane 40 and Aspirn 81 mg for the whole pregnancy with the needed tests as mentioned no evidence of intrauteribe yolk sac yet with no evidence or extra-uterine pregnancy ultrasound picture going with around 4 weeks and by date EDD is 15th of April 2025			
she patient has previous history of more than 3 habitual abortion with a laboratory result showing b-Glucoprotein antibodies positive indicating the prescence of anti-phospholipid syndrome and recquring to perform further tests and special treatment the last LMP WAS 06/07/2024			

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 : 130 T : 37.8 HR : 100 RR : 18

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

Type	Code	Diagnosis
Secondary	D68.61	Antiphospholipid syndrome
Primary	O99.111	Oth dis of bld/bld-form org/immun mechnsm comp preg, 1st tri
Secondary	Z3A.09	9 weeks gestation of pregnancy

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

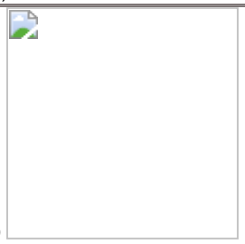
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
0044-387605-1021	(ENOXAPARIN SODIUM : 4000 IU/0.4ML (100 MG/ML)) SOLUTION FOR INJECTION	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 : 06-Sep-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.