eASOAP FORM

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

Patent Name:	**SAPNA BHASKARAN KALATHIL BHASKARAN**	Gender:	**Female**	Validity Between:	**01/01/2024 and 31/12/2024**
Card No:	**8D7D-D316-9537-3037**	DOB:	**9/28/1979 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1978-4125392-1**	Service Date:	**07-Sep-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0543889920**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**44061**	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
PC: Palpitation of sudden onset, difficulty breathing and sweating. Blood pressure checked at the time was said to be high (exact value uncertain). BP at presentation now is 150/104mmhg (elevated). Last meal was 3hours prior. There was also weakness but no dizziness and no loss of conciousness. She's a known hypertensive and PCOS desirous of pregnancy and planning to do IVF.			

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 : 150 T : 36.6 HR : 88 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I16.1	Hypertensive emergency
Secondary	G45.9	Transient cerebral ischemic attack, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	R55	Syncope and collapse

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
84484	Troponin, quantitative	Lab	35.0000
86140	C-reactive protein;	Lab	15.0000
82948	Glucose; blood, reagent strip	Lab	10.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000

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 : **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 : 07-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.