

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	HANAA G M ALBHAISI	Gender:	Male	Validity Between:	19/12/2023 and 18/12/2024
Card No:	7119-2AF0-8B87-97A9	DOB:	1/1/1997 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1995-7427763-0	Service Date:	28-Sep-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	565454958		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	27309	Laboratory:	Covered
Referral No:		Consultaton :			
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 : 105 T : 37.2 HR : 104 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	Z3A.10	10 weeks gestation of pregnancy					

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

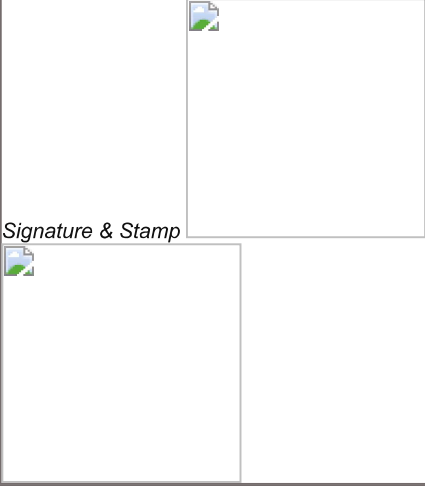
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
86900	Blood typing; ABO	Lab	5.0000
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
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, 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
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
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
N72-0424-00497-01	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	30	Take 1Injection 1Time(s) perDay For 30 Day(s) evening
0321-379305-0511	(THIAMINE (VITAMIN B1) : 100 MG/3 ML) (PYRIDOXINE (VITAMIN B6) : 100 MG/3 ML) (VITAMIN B12 : 1 MG/3 ML) INJECTION	6	Take 1Injection 1 Time(s) per Week For 6 Day(s) others
0005-185902-1173	(FOLIC ACID : 5 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
1291-170901-0391	(DYDROGESTERONE : 10 MG) FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>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> <i>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : MOHAMMED M HAMED		
Tel / Fax (important):		
Signature & Stamp  Patient's Signature(Parent if minor) 		
Date :		
Date : 28-Sep-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

Disclaimer: NEXtCARE ASOAP form is used for claim creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.