eASOAP FORM

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

Patent Name:	**SHAKKIRA ABOOBACKER**	Gender:	**Female**	Validity Between:	**27/10/2023 and 2**
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 Ansa MEDGULF**
Natonal ID:	**784-1995-8960304-3**	Service Date:	**12-Oct-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 Symptom**	
Complaint						DD	MM
No Complaints Found for Selected Appointment							
Past Medical Surgical History?		○ Yes		○ No		**Date of Symptom**	
						DD	MM
Obs/Gyn Claims						**Date of Symptom**	
						DD	MM
☐ 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 : RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Secondary	D68.61	Antiphospholipid syndrome

Type	Code	Diagnosis
Primary	O99.111	Oth dis of bld/bld-form org/immun mechnsm comp preg, 1st tri

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/illne
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

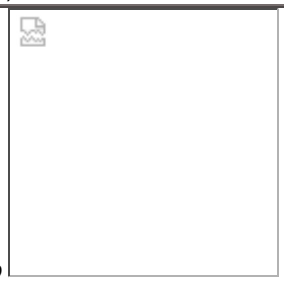
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Pr
10	Specialist Consultation	General Consultation	45

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 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
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 oth release any informaton regarding my medical conditon and history the purpose of determining insurance benefts. Medical managemer 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 : 12-Oct-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 rev
will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE
no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the M
doctors.