

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	JENITHA PALIN	Gender:	Female	Validity Between:	25/01/2024 and 24/01/2025
Card No:	6F14-AAF8-ACF8-4D17	DOB:	9/28/1997 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1997-2802421-9	Service Date:	13-Oct-2024	Radiology:	Covered
		Patent's Tel No:	+919629634911		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42924	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
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 : 96		T : 37		HR : 75		RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Secondary	N91.1	Secondary amenorrhea									
Secondary	N77.1	Vaginitis, vulvitis and vulvovaginitis in dis classd elswhr									
Secondary	E03.9	Hypothyroidism, unspecified									
Secondary	M13.0	Polyarthrititis, unspecified									
Primary	N92.5	Other specified irregular menstruation									

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

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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:		

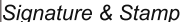
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
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
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
83002	Gonadotropin; luteinizing hormone (LH)	Lab	45.0000
83001	Gonadotropin; follicle stimulating hormone (FSH)	Lab	30.0000
86430	Rheumatoid factor; qualitative	Lab	20.0000
86038	Antinuclear antibodies (ANA);	Lab	25.0000
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
2896-685401-0971	(BIOTIN : 50 MCG) (FOLIC ACID : 800 MCG) (VITAMIN B3 : 25 MG) (VITAMIN B6 : 15 MG) (VITAMIN B2 : 7 MG) (VITAMIN E : 12 MG) (VITAMIN D3 : 400 IU) (ZINC : 15 MG) (DHA (DOCOSAHEXAENOIC ACID) : 250 MG) (VITAMIN B5 : 6 MG) (SELENIUM : 55 MCG) (VITAMIN B12 : 12 MCG) (VITAMIN K : 70 MCG) (EPA (EICOSAPENTAENOIC ACID) : 2.1 MG) (CHROMIUM : 50 MG) (CHROMIUM : 25 MCG) (IRON (CARBONYL IRON) : 28 MG) (VITAMIN B1 : 6 MG) (MAGNESIUM : 57 MG) (MANGANESE : 2 MG) (IODIDE : 150 MCG) (ASCORBIC ACID (VITAMIN C) : 8	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
1204-378702-0391	(*METFORMIN HCL : 500 MG) FILM COATED TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0005-185902-1172	(FOLIC ACID : 5 MG) TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

☐ 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 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 benefets. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : MOHAMMED M HAMED		
Tel / Fax (important):		

 		 <i>Patient's Signature(Parent if minor)</i>
Date :		Date : 13-Oct-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.