# 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 | Polyarthritis, 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)**

| 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: | 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 : 13-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 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.