

eASOAP FORM


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

Patent Name:	CARLA MARIE GARRIDO VILLAMOR	Gender:	Female	Validity Between:	05/02/2024 and 04/02/2025
Card No:	4DE7-3B5B-F5BA-4DFB	DOB:	9/7/1990 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1990-3591495-3	Service Date:	12-Dec-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0522494207		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	44922	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
the patient came complaining of heavy irregular bleeding since the last 3 months by abdominal ultrasound it shows enlarged uterus with thickened endometrium and a mass on the anterior uterine wall by transvaginal ultrasound it gives a picture of intramural uterine fibroid reaching the endometrium measuring 3.5 cm x 4.2 cm the patient was given COC the previous consultation which was effective in the orocess of bleeding control the clinical picture reveal the need to repeat COC AT LEAST FOR AN EXTRA CYCLE FOR MORE BLEEDING CONTRIOL								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 :	T :	HR :	RR :
---------------------	---------------------	-----	------	------

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected**INDICATE DIAGNOSIS NOT SYMPTOM**

Type	Code	Diagnosis
Primary	D25.9	Leiomyoma of uterus, unspecified
Secondary	N93.9	Abnormal uterine and vaginal bleeding, unspecified

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

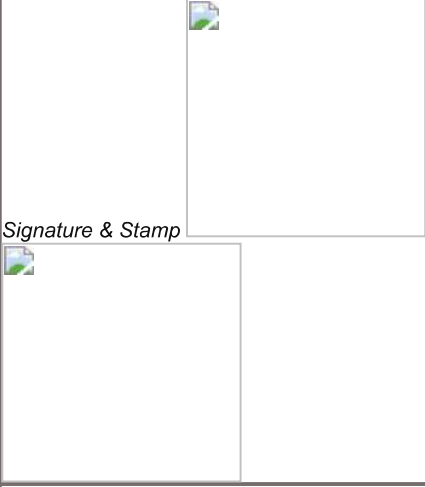
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
76700	Ultrasound, abdominal, real time with image documentation; complete	Radiology	120.0000
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Radiology	80.0000
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
0054-002601-1171	(ETHINYLOESTRADIOL : 0.03 MG) (GESTODENE : 0.075 MG) TABLETS	21	Take 1Tablets 1 Time(s) per Day For 21 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 certify 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):		
		
Date :		Date : 12-Dec-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 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 effects 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.