eASOAP FORM

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

Patent Name:	**Nada Mohamed Elsayed Hefny Hassan**	Gender:	**Female**	Validity Between:	**11/03/2025 and 10/03/2026**
Card No:	**1AAD-E4D2-6464-3B73**	DOB:	**8/9/2001 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2001-2689027-4**	Service Date:	**19-Mar-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0566794711**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46227**	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
by ultrasound there was thickened irregular endometrium by transvaginal ultrasound both ovaries are enlarged and the endomrteial thickness is 13 mm patient came complaining of abnormal uterine bleeding since 2 months with irregular menstruation there is truncal obesity			

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 : T : HR : RR :

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Secondary	E28.2	Polycystic ovarian syndrome
Secondary	R73.02	Impaired glucose tolerance (oral)
Primary	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:

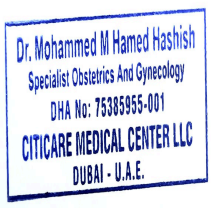
◯ Yes ◯ No	◯ Yes ◯ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
83002	Gonadotropin; luteinizing hormone (LH)	Lab	45.0000
83001	Gonadotropin; follicle stimulating hormone (FSH)	Lab	30.0000
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
1504-340204-1481	(VITAMIN E : 400 IU) CAPSULES (SOFT GELATIN)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0321-164103-2191	(METFORMIN HCL : 500 MG PROLONGED RELEASE TABLETS	30	Take 1Tablets 2 Time(s) per Day For 30 Day(s) others
0005-185902-1173	(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 : 19-Mar-2025	
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.