eASOAP FORM

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

Patent Name:	**MA LENINA FLORES**	Gender:	**Female**	Validity Between:	**06/02/2025 and 05/02/2026**
Card No:	**841A-7357-3D8C-D766**	DOB:	**10/2/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-4159824-1**	Service Date:	**20-May-2025**	Radiology:	**Covered**
		Patent's Tel No:	**+971 50 406 5878**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46147**	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
the patient comes complaining of irregular menstruation in the last two months the flow is irregular associated with low back pain and increased frequency of menstruation by abdominal ultrasound the uterus is bulky enlarged with irregular endometrium by transvaginal ultrasound there is large posterior wall subserous fibroid measuring 9.5 x 5.5 cm intramural fundal fibroid measuring 5.5 x6 cm is seen protruding into the cavity			

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 : 108 T : 37 HR : 61 RR : 18

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

Type	Code	Diagnosis
Primary	N91.2	Amenorrhea, unspecified
Secondary	N84.0	Polyp of corpus uteri

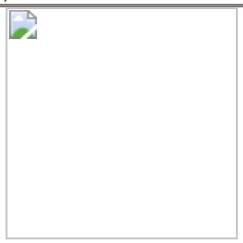
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
1352-437201-1481	(ASCORBIC ACID (VITAMIN C) : 500 MG) (VITAMIN E : 400 IU) CAPSULES (SOFT GELATIN)	30	Take 1Tablets 1 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 : 20-May-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.