

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	MAHBOOBA MIRZOHIDOVA	Gender:	Female	Validity Between:	01/01/2025 and 31/12/2025
Card No:	59AE-6701-A784-D8DE	DOB:	1/10/1987 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	999-9999-9999999-9	Service Date:	05-Jul-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0528482232		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	47336	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 LMP 23/5/2025 GA 5 WEEKS 5 DAYS BY DATE. SINGLE INTRAUTERINE GESTATIONAL SAC OF 6 WEEKS 4 DAYS. GS 28.5MM YOLK SAC AND FETAL POLE SEEN. G2P1 LAST CHILD BORN 2 YEARS BORN THROUGH VAGINAL DELIVERY. LMP 23/5/2025 GA 5 WEEKS 5 DAYS. NAUSEA OFF AND ON. LOWER ABDOMINAL PAIN MILD OFF AND ON. NO URINARY SYMPTOMS.						DD	MM	YYYY			
Past Medical Surgical History?						☐ Yes ☐ No			Date of Symptoms/illness started		
									DD MM YYYY		
Obs/Gyn Claims						☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:			Date of Symptoms/illness started		
									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 : 106		T : 36.6	HR : 78	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	Z3A.01	Less than 8 weeks gestation of pregnancy				

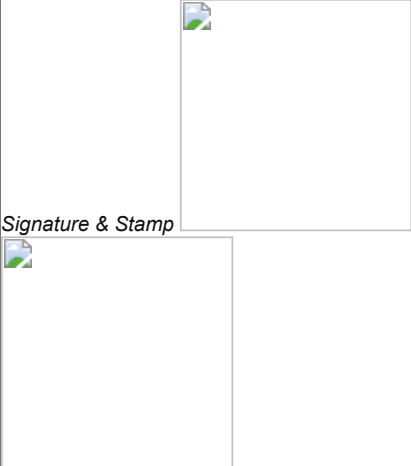
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
10	Specialist Consultation	General Consultation	45.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Lab	5.0000
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	Radiology	80.0000

Code	Generic	Duration	Instructions
0005-185902-1172	(FOLIC ACID : 5 MG) TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal
H21-2006-02450-02	(DEXTROSE : 50 MG/ML) (DEXTRAN 40 : 100 MG/ML) SOLUTION FOR INFUSION	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) after meal

☐ 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 : HUMMAIRA		
Tel / Fax (important):		
		
Date :		Date : 05-Jul-2025

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

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