

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name: MUNA T J KLAIB	Gender: Female	Validity Between: 01/01/2024 and 31/12/2026
Card No: 33DB-EBD3-DBC4-5FF1	DOB: 12/11/1993 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1993-0351514-4	Service Date: 08-Aug-2025	Radiology: Covered
Policy Holder:	Patent's Tel No: 0562906355	
Payer Name: ENAYA	Threshold Limit:	
	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 34084	Pharmacy: Co-Part: 20%
Gatekeeper: No	Consultaton :	Laboratory: Covered
Referral No:		
Referred		
Service:		

SUBJECTIVE ASSESSMENT

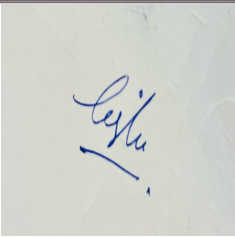
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC : MENSTRUAL PAIN								
PT CAME WITH COMPLAIN OF HEAVY MENSTRAUL BLEEDING ALONG WITH PAIN STARTED TWO DAYS BACK								
SHE LOOK ANEMIC								
HAVING IUD FOR THE LAST ONE YEAR								
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 : 100 T : 36.8 HR : 82 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	N94.6	Dysmenorrhea, unspecified					
Secondary	R10.2	Pelvic and perineal pain					
Secondary	I95.9	Hypotension, unspecified					
Secondary	R50.9	Fever, 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
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0384-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
9	GP Consultation	General Consultation	25.0000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	79.0000
0384-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy	4.5000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	65.0000
Code	Generic	Duration	Instructions
No Prescriptions History Found			
☐ 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 : AISHA		
Tel / Fax (important):		
 Dr. Aisha Umer Physician- General Practitioner DHA- 40131439-002 CITICARE MEDICAL CENTER DUBAI - U.A.E		
Date :	Date : 08-Aug-2025	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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