eASOAP FORM



ADMINISTRATIVE The member is allowed for **Out Patient** at the **Irham Medical Center Arjan**

Patent Name:	JANET ANYANGO AMAKOYE	Gender:	Female	Validity Between:	09/02/2024 and 08/02/2025	
Card No:	3F0D-8FF0-3367-F2D5	DOB:	11/5/1974 12:00:00 AM	Coverage Informaton for:	Out Patient	
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF	
Natonal ID:	784-1974-8741548-7	Service Date:	03-May-2024	Radiology:	Covered	
		Patent's Tel No:	0558331818			
Policy Holder:		Threshold Limit:				
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal			
		Out-Patent :				
Category:	Category B	Patent's File No:	42671	Pharmacy:	Co-Part: 20%	
Gatekeeper:	No	Consultaton :		Laboratory:	Covered	
Referral No:						
Referred						
Service:						
SUBJECTIVE ASSESSMENT						
Symptom(s) as o	Date of Symptoms/illness started					
					IDD MANA MANA	

Past Medical Surgical History? Obs/Gyn Claims Date of Symptoms/illness star 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:192 T:36.9 HR:62 Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary I10 Essential (primary) hypertension Secondary R07.9 Chest pain, unspecified ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)	Symptom(s	as described by the	e patent (Chie	f Complai	nt):			Date o	of Symptom	s/illness started
Oe chest pain sever b.p high Past Medical Surgical History? Obs/Gyn Claims	Complaint				DD	MM	YYYY			
Past Medical Surgical History? Oyes			adache							
Date of Symptoms/illness star Date of Symptoms/illness star DD MMM YYYY Date of Symptoms/illness star DD MMM YYYY Marital Status: Marital Date: Date of Symptoms/illness star DD MMM YYYY Marital Date: Date of Symptoms/illness star DD MMM YYYY Marital Date: DD MMM YEYE DD MMM YYYY Marital Date: DD MMM YEYE DD MMM YE				Over			Date of Symptoms/illness started			
DD MM YYYY DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Marital date did the Patient first feel same / similar Symptom(s): dd mm yyyy s the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when: DBJECTIVE / ASSESSMENT(To be completed by Physician) Vital Signs: B/P: 192 T: 36.9 HR: 62 20 Chronic INDICATE DIAGNOSIS NOT SYMPTOM Suspected INDICATE DIAGNOSIS NOT SYMPTOM Sesential (primary) hypertension Secondary R07.9 Chest pain, unspecified Chest p	rast ivieuit	ai Surgical History:			Yes		O NO	DD	MM	YYYY
Para Gravida: AB: LMP: Marital Status: Marital Date:	Oha/Cua Cl	-:						Date o	of Symptom	s/illness starte
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)	Obs/Gyn Ci	aims						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)	☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Statu	s:	Marital Date:			
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)										
Assessment/Diagnosis: Acute Chronic Suspected	Nhat date d	id the Patient first feel	same / similar	Symptom	(s) : dd mm yyyy	/				
Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary I10 Essential (primary) hypertension Secondary R07.9 Chest pain, unspecified Secondary R51.9 Headache, 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:	s the Patier	nt under any type of Tr	eatment? O	Yes O N	o if yes, indicat	e what Asse	ssment and since w	hen:		
Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary I10 Essential (primary) hypertension Secondary R07.9 Chest pain, unspecified Secondary R51.9 Headache, 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:	DBJECTIVE	: / ASSESSMENT(To	be completed b	ov Physicia	n)					
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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 O Yes No Date of accident or beginning of illness:	Secondar	у	R07.9		Chest pain, unspecified					
Accident or illness due to work? Injury due to road accident? Describe how the accident or work related injury/illness occur: Yes No O Yes No Date of accident or beginning of illness:	Secondar	у	R51.9		Headache, unspecified					
Accident or illness due to work? Ores Ono Describe how the accident or work related injury/illness occur: Ores Ono Date of accident or beginning of illness:	ACCIDENT/	OCCUPATIONAL Clai	m Informatoi	n (comple	te if claim is a re	esult of accid	lent or work related	l illness/inj	ury)	
Date of accident or beginning of illness:	Accident or illness due to work?		II) occribe how the accident or we		vork related	l injury/illne	ss occur:			
• • •	○ Yes ○ No ○ Yes ○		○ No							
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim	Date of acc	ident or beginning o	f illness:	1		1				
	MEDICAL P	LAN Itemized Origina	al Invoices and	d Applicab	le Prescriptions	/ Reports / I	Results must be encl	osed to con	sider claim	

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CPT Code	Treatment					Туре	Price		
9	GP Con	sultation		General Consultation	25.0000				
81001	nitrite,	nalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, rite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, h microscopy							
93005	Electro report	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report Co.Pay 30.000						30.0000	
Code Generic Duration Instructions				S					
4417-71 0391	711202- (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS			7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others				
0207-37 1171	79202-	(AMLODIPINE	(AS BESYLATE) : 10 MG) TABLETS		15	Take 1Table others	1Tablets 2 Time(s) per Day For 15 Day(s)		
OPharm	armacy: Estmated Costs			O Laboratory / Radiology: Est			Estmated Costs		
			O Surgery:	○ Endosc	ору:				
s the follo	ne following required Other Procedures:								
				If yes pleas	se specify				
In-patier	nt Required	d ? Length of Sta	y	Indicate Pr	ovider		Estin	nate Cost	

ls In-patient Required ? Length of Stay	Indicate Provider Estima				
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to				
& that the medical services shown on this form were	release any informaton regarding my medical conditon and history to NEXtCARE for				
medically indicated & necessary for the management of	the purpose of determining insurance benefts. Medical management is the sole				
this case.	responsibility of doctor and the patent.				
Treating Physician Name : Humaira					
Tel / Fax (important):					
Signature & Stamp	Patient's Signature(Parent if minor)				
Date :	Date : 03-May-2024				
Note: Claims must be submited along with supportng doo	cuments 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 final opinion will be given by the NEXtCARE claims doctors.