

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	ABDULLAH ALI	Gender:	Male	Validity Between:	21/02/2024 and 20/02/2025
Card No:	75EA-8385-50D5-BA2C	DOB:	2/8/2023 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2023-1051980-0	Service Date:	07-May-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0551687187		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41033	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

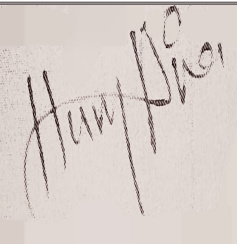
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
co high grade fever vomitting diarrhea abdominal discomfort 3 days								
oe watery diarrhea irritable restless dehydrated								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	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 : 0		T : 37.6		HR : 0		RR	
				: 26							
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	R19.7	Diarrhea, unspecified									
Secondary	R11.10	Vomiting, unspecified									
Secondary	E86.0	Dehydration									

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	
9	GP Consultation	General Consultation	25.0000	
Code	Generic	Duration	Instructions	
No Prescriptions History Found				
☐ Pharmacy:		Estimated Costs	☐ Laboratory / Radiology:	
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 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 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.	
Treating Physician Name : Humaira			
Tel / Fax (important):			
 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.		 Patient's Signature(Parent if minor)	
Date :		Date : 07-May-2024	
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 responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.