

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	Kalkedan Tasew Herpa	Gender:	Male	Validity Between:	28/02/2024 and 08/02/2025
Card No:	57BC-47BA-07C1-0078	DOB:	11/21/1994 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1994-5612161-7	Service Date:	12-May-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0588136035		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43101	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
Cough								
running nose								
Headache X 2day								
Fever X 1day								
Generalized weakness X 1day								
L.M.P: 9/05/2024								
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 : 107 T : 37.7 HR : 107 RR : 20			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J10.1	Flu due to oth ident influenza virus w oth resp manifest					
Secondary	J03.91	Acute recurrent tonsillitis, unspecified					

Type	Code	Diagnosis
Secondary	J00	Acute nasopharyngitis [common cold]

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:		

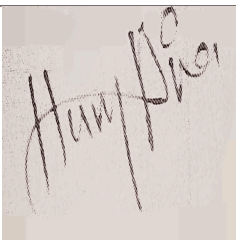
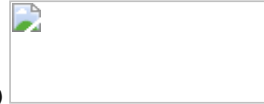
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	15.5000
86140	C-reactive protein;	Lab	15.0000
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Lab	5.0000

Code	Generic	Duration	Instructions
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	7	Take 1Syrup 3 Time(s) per Day For 7 Day(s) after meal
0005-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0096-106304-0271	(ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
4179-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 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 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 : 12-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 creation 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 final opinion will be given by the NEXtCARE claims doctors.