

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 Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1974-8741548-7	Service Date:	18-May-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0558331818		
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	Consultation :		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
Bilateral leg swelling for the past 7days. Said to have began after she commenced amlodipine which was given on account of high blood pressure and chest pain. There is no cough, no difficulty breathing and no paroxysmal nocturnal dyspnea. She was said to have been managed as a case of hypertensive emergency as BP at presentation that day was 197/110mmhg (as told by the patient). She is not diabetic and has no other medical condition of note. Exam: Bilateral pitting edema. PR = 98 regular and normal volume. BP=143/90mmhg Patient is counselled on the need for weight reduction and dietary modification with low salt and sodium in diet.								
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started		
						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 : 126 : 18	T : 37.2	HR : 104	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
 INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R60.9	Edema, unspecified
Secondary	I10	Essential (primary) hypertension

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

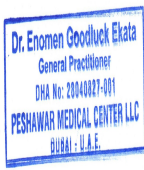
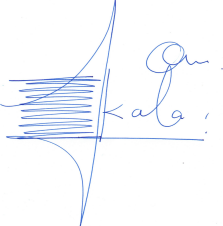
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
80076	Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)	Lab	85.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0027-151102-0391	(VALSARTAN : 160 MG) (HYDROCHLOROTHIAZIDE : 25 MG) FILM COATED TABLETS	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) morning

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
Is the following required	☐ Surgery:	☐ Endoscopy:	
	☐ Physiotherapy:	☐ Other Procedures:	
		If yes please specify	

5/18/24, 12:13 PM

ClinicSoft 8.0 - NextCare Form

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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
Signature & Stamp 	 Patient's Signature(Parent if minor)	
Date :		
Date : 18-May-2024		
Note: Claims must be submited along with supportng 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.