

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	ASHA THATTASSERIL PADMAVATHY NEELAKANDAN	Gender:	Female	Validity Between:	25/11/2023 and 24/11/2024
Card No:	7504-3D2B-B81F-852B	DOB:	5/25/1978 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
National ID:	784-1978-7310218-6	Service Date:	21-May-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0564999790		
		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	37217	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint Cough productive of clear mucus Fever and generalized body pains, especially low back pain. Hydradenitis suppurativa still present, as she has seen the surgeon for a while. She is counselled to keep visiting her general surgeon.						DD	MM	YYYY
Past Medical Surgical History?			☐ Yes	☐ No	Date of Symptoms/illness started			
					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 : 132		T : 37.7		HR : 88		RR	
				: 20							
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	J06.9	Acute upper respiratory infection, unspecified									
Secondary	L73.2	Hidradenitis suppurativa									
Secondary	M54.5	Low back pain									

Type	Code	Diagnosis
Secondary	R50.9	Fever, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

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:		

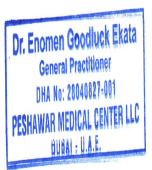
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
0005-141607-1111	(ALUMINIUM HYDROXIDE : 215 MG/5 ML) (SIMETHICONE : 25 MG/5ML) (MAGNESIUM HYDROXIDE : 80 MG/5ML) SUSPENSION	5	Take 10ML 4 Time(s) per Day For 5 Day(s) after meal
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0137-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
5098-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal

☐ Pharmacy:	Estmated Costs	☐ Laboratory / Radiology:	Estmated 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 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>		<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 : Enomen Goodluck		
Tel / Fax (important):		

<i>Signature & Stamp</i> 	<i>Patient's Signature(Parent if minor)</i> 
Date :	Date : 21-May-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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