

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	Sinta Natalia Taopan	Gender:	Female	Validity Between:	25/10/2023 and 24/10/2024
Card No:	93BA-99E0-050E-7D2A	DOB:	12/26/2001 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2002-9900551-0	Service Date:	23-May-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0552175547		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43201	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 fever dry cough ear blokage and pain 1 week								
oe inthe ear rt side lacerations present red all the region								
chest is congested no added sounds vitals stable								
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 : 111 T : 36.7 HR : 97 RR : 18		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	H66.90	Otitis media, unspecified, unspecified ear			
Secondary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	R05	Cough			

Type	Code	Diagnosis
Secondary	R50.9	Fever, unspecified
Secondary	K29.70	Gastritis, unspecified, without bleeding

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:		

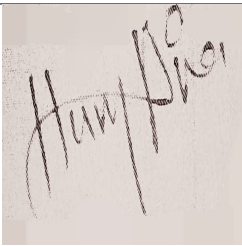
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0195-107704-0801	CEFTRIAZONE-TABUK IV-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
86140	C-reactive protein;	Lab	15.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Syrup 1 Time(s) per Day For 5 Day(s) others
0097-393801-2471	(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	2	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0005-533801-1451	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) CAPSULES (HARD GELATIN)	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others
0005-119805-1171	(PREDNISOLONE : 5 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0005-116604-1171	(METRONIDAZOLE : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1 Unit(s), 2 Time(s) per Day For 7 Day(s)

☐ 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 benefits. 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.	
Date :	Date : 23-May-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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