

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	ANTONY KIM KANNAN KANNAN SWAMINATHAN	Gender:	Male	Validity Between:	15/06/2023 and 14/06/2024
Card No:	60B8-0C70-5A39-75E3	DOB:	6/13/1993 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natnol ID:	784-1993-1925086-8	Service Date:	25-May-2024	Radiology:	Covered
		Patent's Tel No:	0509207474		
Policy Holder:		Threshold Limit:			
Payer Name:	MetLife	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	35224	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 Recurrent belching, and diarrhea since the past 1hour. . Has had over 3 episodes of diarrhea. Has a previous history of acute gastritis. Not hypertensive and not diabetic but has a history of anxiety disorder.						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		
						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 : 134	T : 36.5	HR : 95	RR : 20
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	K29.00	Acute gastritis without bleeding				
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis				

Type	Code	Diagnosis
Secondary	R19.7	Diarrhea, unspecified
Secondary	F41.1	Generalized anxiety disorder
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:		

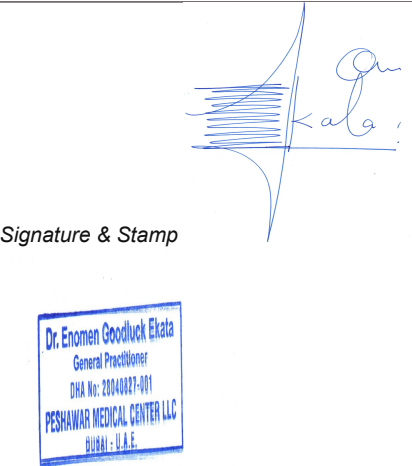
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
86677	Antibody; Helicobacter pylori	Lab	25.0000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	General Consultation	8.4000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0005-141607-1113	(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) others
0265-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) others
1614-530501-0611	(DEXLANSOPRAZOLE : 60 MG) MODIFIED RELEASE CAPSULES	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) before 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>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 benefets. 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 : 25-May-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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