eASOAP FORM

Assessment/Diagnosis : Acute Chr
INDICATE DIAGNOSIS NOT SYMPTOM

Code

J03.90

H66.91

Type

Primary

Secondary



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the Irham Medical Center Arjan

Patent Name:	AREEBA AFTAB MUHAMMAD ALI FAROOQ	Gender:	Female	Validity Between:	21/02	21/02/2024 and 20/02/2025			
Card No:	F8A2-7B44-BC32-871E	DOB:	3/19/1999 12:00:00 AM	Coverage Informaton for:	Out I	Out Patient			
Pin #:		Identty Card:		Network:		AE (Al Ansa GULF	ri-AUH)-		
Natonal ID:	784-1999-6072917-8	Service Date: Patent's Tel No Threshold	27-May-2024 b: 0585387187	Radiology:	Cove	Covered			
Policy Holder:		Limit:							
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal						
		Out-Patent :							
Category:	Category B	Patent's File No:	40172	Pharmacy:	Co-Pa	art: 20%			
Gatekeeper:	No	Consultaton :		Laboratory:	Cove	Covered			
Referral No:									
Referred Service:									
SUBJECTIVE AS	SESSMENT								
Symptom(s) as	described by the patent (Date o	Date of Symptoms/illness started						
Complaint			DD	MM	YYYY				
co fever epigastric pain pain in throat ear pain 2 days couh dry									
oe ear is pain	enlarge tonsils								
chest is conge	ested no added sounds								
Past Medical Surgical History?						of Symptom	s/illness started		
Past ivieuicai s	urgicai mistory:			○ No	DD	MM	YYYY		
					Data	-f C to	- /:ll======t==t==		
Obs/Gyn Claims							s/illness started		
Para	Gravida: AE	3: LMP: M	larital Status:	Marital Date:	DD	MM			
What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy									
Is the Patient un	der any type of Treatment?	○ Yes ○ No if	yes, indicate what Ass	essment and since where	า:				
OBJECTIVE / A	SSESSMENT(To be comple	eted by Physician)							
Clinical Findings: Vital Signs: B/P:92 T:38.3 HR:117 R									

: 18

Acute tonsillitis, unspecified

Otitis media, unspecified, right ear

○ Chronic

Diagnosis

○ Confirmed ○ Suspected

Secondary R32 Pain, unspecified	Туре	Code		Dia	Diagnosis							
ACCIDENT/OCCUPATIONAL Claim Information (complete if claim is a result of accident or work related illness/injury) Accident or riliness due to work? Impury due to road accident? Describe how the accident or work related injury/illness occur:	Secondary		R50.9		Fev	Fever, unspecified						
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related liliness/injury) Accident or illness due to work? Injury due to road accident or illness due to work? Oves O No Date of accident or beginning of illness: Over O No Date of accident or beginning of accident or beginning of accident or work related in consistence or Date of accide	Secondary		R52		Pair	Pain, unspecified						
Accident or illness due to work? Injury due to road Describe how the accident or work related injury/illness occur: Yes No	Secondary K29.70		70	Gas	Gastritis, unspecified, without bleeding							
Accident or illness due to work? Injury due to road Describe how the accident or work related injury/illness occur: Yes No	ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)											
Oves O No Date of accident or beginning of illness: Procedure	Assident or illness due to work?					y due to road Describe how the assident or work related injury/illness occur:						
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Price GPT Code Treatment GPT Code GP Consultation GPT Consultation Con-pay 10,0000 1003-149902- 1021 CLOFEN (DICLOFENAC SODIUM: 75 MG/3ML) SOLUTION FOR INJECTION Pharmacy GPT CON-PARAFUSIV IV. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INJECTION Pharmacy GPT CON-PARAFUSIV IV. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INJECTION Pharmacy GPT CON-PARAFUSIV IV. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INJECTION Pharmacy GPT CON-PARAFUSIV IV. 10MG/ML-(PARACETAMOL: 16) POWDER FOR INJECTION Pharmacy A8.5000 GPT CON-PARAFUSIV IV. 10MG/ML-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy A8.5000 BESOLUTION FOR INJECTION Pharmacy A8.5000 GPT CON-PARAFUSIV IV. 10MG/ML-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy A8.5000 BESOLUTION FOR INJECTION Pharmacy A8.5000 BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy A8.5000 BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy Lab BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy A8.5000 Pharmacy Lab BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy Lab BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy Lab BESOLUTION FOR INJECTION Pharmacy A8.5000 Pharmacy Take 1Tablets 1 Time(s) per Day For 7 Day(s) others Take 1Tablets 1 Time(s) per Day For 7 Day(s) others Take 1Tablets 2 Time(s) per Day For 7 Day(s) others Take 1Tablets 2 Time(s) per Day For 7 Day(s) others Pharmacy: Estimated Costs Physician Name: Humalira BESUmated Costs Ferentically indicated 8 necessary for the management of the purpose of determining insurance benefits. Medical management is the sole repose position and history to NEXICARE for the purpose of determining insurance benefits. Medical management is the sole repose posit	○ Yes ○ No											
CPT Code Treatment Type Price Price		r beginning	of illn	ess:		-						
9 GP Consultation General Consultation 25,0000 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular 10,0000 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour 40,0000 0005-149902-1021 CLOFEN - (DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION Pharmacy 6,5000 1019-1307704- DEPARAFUSIV IV. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INJECTION Pharmacy 8,4000 1019-1307704- DEFINATION - (CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION Pharmacy 48,5000 85652 Sedimentation rate, erythrocyte; automated Lab 8,0000 85652 Sedimentation rate, erythrocyte; automated High, Hct, RBC, WBC and platelet count) and automated differential WBC count 4335-33801 (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT 7 Take 1Tablets 1 Time(s) per Day For 7 Tablets 1 Tablets 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1 Tablets 1 Time(s) per Day F	MEDICAL PLAN Ite											
Section Consultation Certification C	CPT Code	Treatmer	nt							Туре	Price	
subcutaneous or intramuscular 103635 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); 1021 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); 1021 Co.Pay 40.0000 1005-149902- CLOFEN - (DICLOFENAC SODIUM: 75 MG/3ML) SOLUTION FOR INJECTION Pharmacy 6.5000 1019-107704- PARAFUSIV I.V. 10MG/ML-(PARACETAMOL: 10 MG/ML) SOLUTION FOR INJECTION Pharmacy 8.4000 1019-107704- CEFTRIAXONE-TABUK IV-(CEFTRIAXONE: 1 G) POWDER FOR INJECTION Pharmacy 48.5000 85652 Sedimentation rate, erythrocyte; automated Lab 8.0000 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 Code Generic Pharmacy Injection Instructions 4235-533801- (ESOMEPRAZOLE (AS MAGNESIUM): 20 MG) GASTRO-RESISTANT 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1025-179601- (AMMONIUM CHLORIDE: N/A) (MENTHOL: N/A) 2 Day(s) others 1005-116004- (CAFFEINE: 65 MG) (PARACETAMOL: 500 MG) CAPLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 1 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE: 500 MG) TABLETS 7 Take 1 Tablets 2 Time(s) per Day For 7 Day(s) others 1005-116604- (METRONIDAZOLE:	9	GP Consultation								25.0000		
Initial, up to 1 hour Co.Pay 40.000	96372							drug);	Co.Pay 10.0000			
CLOFEN - [DICLOFENAC SODIUM : 75 MG/3ML] SOLUTION FOR INJECTION Pharmacy 6.5000 2190-106618- 1001 0195-107704- 0801 CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION Pharmacy 48.5000 85652 Sedimentation rate, erythrocyte; automated Lab 8.0000 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 Code Generic 4235-533801- (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT 7 Take 17ablets 1 Time(s) per Day For 7 1751 TABLETS 0252-179601- (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) 2 Take 17ablets 2 Time(s) per Day For 7 1005-107001- (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 Take 17ablets 2 Time(s) per Day For 7 1071 Take 17ablets 2 Time(s) per Day For 7 1072 Take 17ablets 2 Time(s) per Day For 7 1072 Take 17ablets 2 Time(s) per Day For 7 1073 Take 17ablets 2 Time(s) per Day For 7 1074 Take 17ablets 2 Time(s) per Day For 7 1075 Take 17ablets 2 Time(s) per Day For 7 1075 Take 17ablets 2 Time(s) per Day For 7 1075 Take 17ablets 2 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1075 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 1 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1077 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1076 Take 17ablets 2 Time(s) per Day For 7 1077 Take 17ablets 2 Time(s) per Day For 7 1078 Take 17ablets 2 Time(s) per Day For 7 1079 Take 1	96365							rug);	Co.Pay	40.0000		
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Sedimentation rate, erythrocyte; automated Lab R.0000		PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION Pharmacy 8.400							8.4000			
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count Lab 20.0000		CEFTRIAXONE-TABUK IV-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION Pharmacy 48.500							48.5000			
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count Code Generic Duration Instructions 4235-533801- (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others 0252-179601- (AMMONIUM CHLORIDE : N/A) (MENTHOL : N/A) 2 Day(s) others 0005-107001- (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) others 0005-116604- (METRONIDAZOLE : 500 MG) TABLETS 7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) others 0219-148602- (CLARITHROMYCIN : 500 MG) FILM COATED TABLETS 7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) others OP Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs Is In-patient Required ? Length of Stay Indicated Provider Estimate Cost 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 the purpose of determining insurance benefts. Medical management is the sole tresponsibility of dactor and the patent. Treating Physician Name : Humaira Duration Instructions 1	85652	Sedimentation rate, erythrocyte; automated							Lab	8.0000		
Code Generic Duration Instructions	86140	C-reactive protein;							Lab	15.0000		
4235-533801- 1751 TABLETS 7 TABLETS 7 TABLETS 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others 0252-179601- 1161 (DIPHENHYDRAMINE : 14 MG/5 ML) SYRUP 2 Day(s) others 0005-107001- 0051 (CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS 7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) others 0005-116604- 1171 (METRONIDAZOLE : 500 MG) TABLETS 7 Take 1Tablets 2 Time(s) per Day For 7 Day(s) others 0219-148602- 0391 (CLARITHROMYCIN : 500 MG) FILM COATED TABLETS 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others OTHER ORDER OF TABLETS 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others OTHER ORDER OF TABLETS 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others OTHER ORDER O	85025									20.0000		
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Day(s) others		, , ,						2				
1171 (METRONIDAZOLE: 500 MIG) TABLETS / Day(s) others 0219-148602- 0391 (CLARITHROMYCIN: 500 MG) FILM COATED TABLETS 7 Take 1Tablets 1 Time(s) per Day For 7 Day(s) others Pharmacy: Estmated Costs		(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPL					ETS	7				
Ose Pharmacy: Estmated Costs Laboratory / Radiology: Estmated Costs Surgery: Other Procedures: If yes please specify Indicate Provider Estimate Cost Inhereby certfy that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Humaira Estmated Costs Indicate Provider Estimate Cost I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.		(METRONIDAZOLE : 500 MG) TABLETS					7					
Surgery: Physiotherapy: If yes please specify Indicate Provider In		(CLARITHROMYCIN : 500 MG) FILM COATED TABLETS					S	7				
Is the following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Indicate Provider Indicate Provider, Insurer, Employer or other Organizaton to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole tresponsibility of doctor and the patent. Treating Physician Name: Humaira	O Pharmacy: Estmated		Estmated (Costs Caboratory / F			adiology:	Estmated Costs				
If yes please specify Indicate Provider Indicate	Is the following required			O Surgery:			○ Endoscopy:					
Is In-patient Required? Length of Stay Indicate Provider 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 condition 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				O Physiotherapy:			Other Procedures:					
I hereby certfy that all informaton mentoned are correct & the 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 condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Humaira					If yes please specify							
I hereby certfy that all informaton mentoned are correct & the 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 condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Humaira	Is In-patient Required ? Length of Stay Indicate Provider Estimate Cost											
	I hereby certfy that all informaton mentoned are correct & the medical services shown on this form were medically indicated & necessary for the management of the purpose of determining insurance benefts. Medical management is the sole						rganizaton to EXtCARE for					
Tel / Fax (important):		Name : Hum	naira									
	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 : 27-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 efects 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.