

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	ROSALIE SUMUBA MUNGICAL	Gender:	Female	Validity Between:	02/02/2024 and 01/02/2025
Card No:	BEEC-BF5B-DBE1-C8F9	DOB:	2/18/1982 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1982-6986849-7	Service Date:	29-May-2024	Radiology:	Covered
		Patent's Tel No:	0553341023		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43250	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
Symptoms: Nasal congestion, nasal discharge, coughing (dry).								
Duration/onset: 27/05/2024 (2days).								
History of presenting complaint: Associated sneezing, itching throat, no fever.								
Past medical history: Not hypertensive, not diabetic, not asthmatic and has no chronic illness.								
Family history: No family history of asthma								
Allergy: none.								
Social history: Does not smoke nor take alcohol.								
Occupation: Live out nanny.								
Menstrual history: LMP = unsure ??								
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 : 120	T : 36.8	HR : 0	RR
	: 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	J30.9	Allergic rhinitis, unspecified
Secondary	J01.40	Acute pansinusitis, unspecified
Secondary	J02.9	Acute pharyngitis, unspecified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

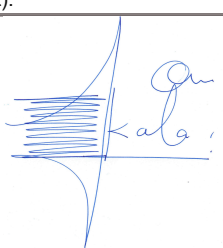
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

Code	Generic	Duration	Instructions
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	8	Take 1Tablets 2Time(s) perDay For 8 Day(s) after meal
0027-128802-2021	(XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS	5	Take 2Drops 3 Time(s) per Day For 5 Day(s) others
0070-148701-1171	(LORATADINE : 10 MG) TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after 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 : 29-May-2024

Note: Claims must be submitted along with supporting 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.