

# eASOAP FORM



## ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

|                      |                                     |                      |                                 |                             |                                            |
|----------------------|-------------------------------------|----------------------|---------------------------------|-----------------------------|--------------------------------------------|
| Patent Name:         | <b>SABITRI SAPKOTA<br/>SAPKOTA</b>  | Gender:              | <b>Female</b>                   | Validity Between:           | <b>06/12/2023 and 05/12/2024</b>           |
| Card No:             | <b>9D09-A8C6-51D8-1524</b>          | DOB:                 | <b>8/4/1989 12:00:00<br/>AM</b> | Coverage Informaton<br>for: | <b>Out Patient</b>                         |
| Pin #:               |                                     | Identty Card:        |                                 | Network:                    | <b>RN UAE (Al Ansari-AUH)-<br/>MEDGULF</b> |
| Natonal ID:          | <b>784-1989-7293970-0</b>           | Service Date:        | <b>31-May-2024</b>              | Radiology:                  | <b>Covered</b>                             |
|                      |                                     | Patent's Tel No:     | <b>0561039734</b>               |                             |                                            |
| Policy Holder:       |                                     | Threshold<br>Limit:  |                                 |                             |                                            |
| Payer Name:          | <b>ORIENT INSURANCE<br/>P.J.S.C</b> | Class:               | <b>Normal</b>                   |                             |                                            |
|                      |                                     | Out-Patent :         |                                 |                             |                                            |
| Category:            | <b>Category B</b>                   | Patent's File<br>No: | <b>43268</b>                    | Pharmacy:                   | <b>Co-Part: 20%</b>                        |
| Gatekeeper:          | <b>No</b>                           | Consultaton :        |                                 | Laboratory:                 | <b>Covered</b>                             |
| Referral No:         |                                     |                      |                                 |                             |                                            |
| Referred<br>Service: |                                     |                      |                                 |                             |                                            |

## SUBJECTIVE ASSESSMENT

| Symptom(s) as described by the patient (Chief Complaint):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Date of Symptoms/illness started |    |      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|----|------|
| <b>Complaint</b><br><br>PC: Fever, vomiting, dizzines.<br><br>Duration: 30/05/2024 (2days).<br><br>HPC: Fever is high grade fever and unresponsive to PCM. Had 2 episodes of billious vomiting, which contained also recently ingested meals. There is no cough, but has mild pain in throat, no chest pain, no abdominal pain, no change in bowel habit.<br><br>Past medical conditino: she not hypertensive, not diabetic and has no other medical condition of note.<br><br>Family history: not relevant<br><br>Social history: Does not smoke and does not take alcohol.<br><br>Menstrual: LMP: 22/05/2024, not pregnant, not breastfeeding and not on any contraception.<br><br>Travel history: Nil<br><br>Occupation: Nanny. |  | DD                               | MM | YYYY |

|                                                                                                                                                 |                                   |                              |                          |                                  |               |      |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------|--------------------------|----------------------------------|---------------|------|
| Past Medical Surgical History?                                                                                                                  |                                   | <input type="radio"/> Yes    | <input type="radio"/> No | Date of Symptoms/illness started |               |      |
|                                                                                                                                                 |                                   |                              |                          | DD                               | MM            | YYYY |
| Obs/Gyn Claims                                                                                                                                  |                                   |                              |                          | Date of Symptoms/illness started |               |      |
|                                                                                                                                                 |                                   |                              |                          | DD                               | MM            | YYYY |
| <input type="checkbox"/> Para                                                                                                                   | <input type="checkbox"/> Gravida: | <input type="checkbox"/> 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? <input type="radio"/> Yes <input type="radio"/> No if yes, indicate what Assessment and since when: |                                   |                              |                          |                                  |               |      |

**OBJECTIVE / ASSESSMENT**(To be completed by Physician)

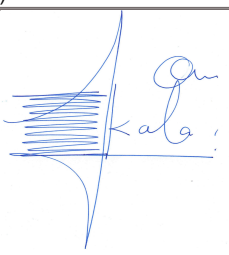
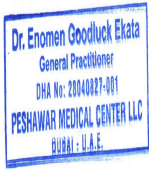
| Clinical Findings :                                                                                                                                                                       |        | Vital Signs : B/P : 104 T : 39.1 HR : 126 RR : 18  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------|--|--|--|
| Assessment/Diagnosis : <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Confirmed <input type="radio"/> Suspected<br><b>INDICATE DIAGNOSIS NOT SYMPTOM</b> |        |                                                    |  |  |  |
| Type                                                                                                                                                                                      | Code   | Diagnosis                                          |  |  |  |
| Primary                                                                                                                                                                                   | N39.0  | Urinary tract infection, site not specified        |  |  |  |
| Secondary                                                                                                                                                                                 | J03.80 | Acute tonsillitis due to other specified organisms |  |  |  |
| Secondary                                                                                                                                                                                 | J02.9  | Acute pharyngitis, unspecified                     |  |  |  |
| Secondary                                                                                                                                                                                 | R50.9  | Fever, unspecified                                 |  |  |  |
| Secondary                                                                                                                                                                                 | R11.10 | Vomiting, unspecified                              |  |  |  |
| Secondary                                                                                                                                                                                 | M79.10 | Myalgia, unspecified site                          |  |  |  |

| 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: |
| <input type="radio"/> Yes <input type="radio"/> No                                                                          |                                                                                                               | <input type="radio"/> Yes <input type="radio"/> 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                                                         |
| 96372                                                                                                                       | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | Co.Pay                                             | 10.0000                                                         |

| CPT Code         | Treatment                                                                                                                                                                                                              | Type     | Price   |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------|
| 96365            | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour                                                                                                        | Co.Pay   | 40.0000 |
| 0005-107704-0802 | TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION                                                                                                                                                                 | Pharmacy | 58.5000 |
| 0125-122107-1022 | DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION                                                                                                                                        | Pharmacy | 2.3400  |
| 0005-149902-1021 | CLOFEN                                                                                                                                                                                                                 | Pharmacy | 6.5000  |
| 81001            | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy | 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                                                                                                    | Lab      | 20.0000 |

| Code             | Generic                                                                                        | Duration | Instructions                                             |
|------------------|------------------------------------------------------------------------------------------------|----------|----------------------------------------------------------|
| 0139-116207-1171 | (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS                                      | 10       | Take 1Tablets 2 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 2 Time(s) per Day For 10 Day(s) after meal |
| 0005-119805-1172 | (PREDNISOLONE : 5 MG) TABLETS                                                                  | 7        | Take 2Tablets 1 Time(s) per Day For 7 Day(s) after meal  |
| 1516-107902-1171 | (IBUPROFEN : 400 MG) TABLETS                                                                   | 5        | Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal  |

|                                 |                                      |                                               |                 |
|---------------------------------|--------------------------------------|-----------------------------------------------|-----------------|
| <input type="radio"/> Pharmacy: | Estimated Costs                      | <input type="radio"/> Laboratory / Radiology: | Estimated Costs |
| Is the following required       | <input type="radio"/> Surgery:       | <input type="radio"/> Endoscopy:              |                 |
|                                 | <input type="radio"/> Physiotherapy: | <input type="radio"/> Other Procedures:       |                 |
|                                 | If yes please specify                |                                               |                 |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                  |               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------|
| Is In-patient Required ? Length of Stay                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Indicate Provider                                                                                                                | Estimate Cost |
| <p><i>I hereby certify that all informaton mentoned are correct &amp; that the medical services shown on this form were medically indicated &amp; necessary for the management of this case.</i></p> <p><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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i></p> |                                                                                                                                  |               |
| Treating Physician Name : <b>Enomen Goodluck</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                  |               |
| Tel / Fax (important):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                  |               |
| <p>Signature &amp; Stamp</p>                                                                                                                                                                                                                                                                                                               | <p>Patient's Signature(Parent if minor)</p>  |               |

|                                                                                                    |                    |
|----------------------------------------------------------------------------------------------------|--------------------|
| Date :                                                                                             | Date : 31-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 creation 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 final opinion will be given by the NEXtCARE claims doctors.