eASOAP FORM

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

Patent Name:	**MOHAMMED ABUL FAZAL HAJEE ALI AHMED**	Gender:	**Male**	Validity Between:	**07/12/2023 and 06/12/2024**
Card No:	**0E78-7BD6-2B00-B91A**	DOB:	**5/17/1965 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1965-9596925-2**	Service Date:	**31-May-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0558743379**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**36862**	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**		
	DD	MM	YYYY
Complaint PC: Frequency of urine, nocturia, also pruritic rashes of skin Duration: Recurrent since 1months (02/04/2024) Past medical history: Known hyperlipidemia patient, also BPH patient, known hypertensive but not diabetic. Family history: not significant. Drug: Tamsulosin.			

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 : 123 T : 36.5 HR : 68 RR : 20

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	E11.65	Type 2 diabetes mellitus with hyperglycemia
Secondary	N40.1	Benign prostatic hyperplasia with lower urinary tract symp

Type	Code	Diagnosis
Secondary	I10	Essential (primary) hypertension
Secondary	L30.9	Dermatitis, unspecified
Secondary	L43.9	Lichen planus, unspecified
Secondary	M79.2	Neuralgia and neuritis, unspecified

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

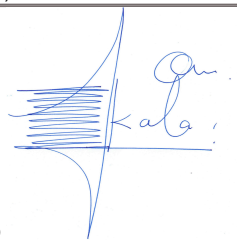
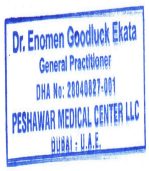
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
0321-379305-0511	(THIAMINE (VITAMIN B1) : 100 MG/3 ML) (PYRIDOXINE (VITAMIN B6) : 100 MG/3 ML) (VITAMIN B12 : 1 MG/3 ML) INJECTION	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening
0137-242801-0342	(PANTOPRAZOLE (AS SODIUM) : 20 MG) ENTERIC COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) before meal
0137-238401-1451	(TAMSULOSIN HCL : 0.4 MG) CAPSULES (HARD GELATIN)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening
0070-124403-0151	(MOMETASONE FUROATE : 0.1%) CREAM	2	Take 1Cream 1 Time(s) per Day For 2 Day(s) others
0070-148701-1171	(LORATADINE : 10 MG) TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	7	Take 1Tablets 1Time(s) perDay For 7 Day(s) after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Enomen Goodluck**		
Tel / Fax (important):		
 *Signature & Stamp* 	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 31-May-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.