eASOAP FORM

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

Patent Name:	**SAMEERA ALI USMAN**	Gender:	**Female**	Validity Between:	**22/07/2023 and 21/07/2024**
Card No:	**5B9B-0397-1368-6CC9**	DOB:	**10/1/1995 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-1706506-8**	Service Date:	**01-Jun-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502295430**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40702**	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
PC: Pain in the right flank Duration: 30/05/2024 (2days) HPC: Pain is located in the right flank and colicky in nature, she had previously presented with similar complaint and hematuria (blood in urine), and was subsequently referred to urologist. The urologist appointment is in 3days (on Tuesday), only for pain to begin again last night. She has nausea but has not vomited. Past medical history: has similar conditions in the past on multiple occasion, not hypertensive and not diabetic. Family history: not relevant Social history: does not smoke and does not take alcohol. Exam: marked right renal angle tenderness.			

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 : 118 T : 36.8 HR : 108 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	N20.2	Calculus of kidney with calculus of ureter
Secondary	R10.31	Right lower quadrant pain
Secondary	N23	Unspecified renal colic
Secondary	K29.00	Acute gastritis without bleeding

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
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0046-149902-0511	Infla-Ban (Diclofenac Sodium [75 Mg/3ml]) Injection (5 X 3ml, Ampoule)	Pharmacy	15.5000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000

Code	Generic	Duration	Instructions
0188-232401-0391	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0135-223401-1171	(NAPROXEN : 500 MG) TABLETS	3	Take 1Tablets 3 Time(s) per Day For 3 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 Dr. Enomen Goodluck Ekata General Practitioner DHA No: 20040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)*** 
Date :	Date : 01-Jun-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	