## **eASOAP FORM**



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

Patent Name: JANET ANYANGO

Gondon: Female Validity Potwoon: 09/02/2024 and 08/02/2025

09/02/2024 and 08/02/2025 Patent Name: Gender: **Female** Validity Between: **AMAKOYE** 11/5/1974 12:00:00 Coverage Informaton 3F0D-8FF0-3367-F2D5 Card No: DOB: **Out Patient** AM RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-1974-8741548-7 Service Date: 02-Jun-2024 Radiology: Covered Patent's Tel No: 0558331818 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File 42671 Category: **Category B** Pharmacy: Co-Part: 20% No: Gatekeeper: Consultation: Laboratory: Covered No Referral No: Referred

## SUBJECTIVE ASSESSMENT

Service:

Past Medical Surgical History?  Obs/Gyn Claims  Date of Symptoms/illness starts DD MM YYYY  Date of Symptoms/illness starts DD MM YYYY  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:36.6 HR:56  : 18  Assessment/Diagnosis: Acute Chronic INDICATE DIAGNOSIS NOT SYMPTOM  Type  Code  Diagnosis  Primary  I10  Essential (primary) hypertension  Secondary  R51.9  Headache, unspecified	Symptom(s)	as described by the p	patent (Chief	Complair	nt):		Date	of Symptoms	s/illness starte	
oe chest is clear no added sounds stable  Past Medical Surgical History?  Obs/Gyn Claims  Obate of Symptoms/illness starte  DD MM YYYY  Marital Date:  Obs/Gyn Claims  Obs/Gyn	Complaint	:	DD	MM	YYYY					
Past Medical Surgical History?  Obs/Gyn Claims  Obs/Gyn Claims	co headac	he 1 day								
Past Medical Surgical History?  Obs/Gyn Claims  Obs/Gyn Claims	oe chest is	s clear no added sound	ds							
Past Medical Surgical History?  Obs/Gyn Claims  Date of Symptoms/illness starts DD MM YYYY  Date of Symptoms/illness starts DD MM YYYY  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:36.6 HR:56  : 18  Assessment/Diagnosis: Acute Chronic Suspected INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified	stable									
Obs/Gyn Claims  Obs/Gyn Claims  Date of Symptoms/illness starts DD MM YYYY  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:36.6 HR:56  : 18  Assessment/Diagnosis: Acute Chronic Signs Symptoms  Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified	Past Medica	al Surgical History?	Date	Date of Symptoms/illness started						
Obs/Gyn Claims  OD 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:36.6 HR:56  : 18  Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified	r ast ivicuite	ar Surgical History:			O les		DD	MM	YYYY	
Obs/Gyn Claims  OD 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:36.6 HR:56  : 18  Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified							Data	-f ()	a /:llm and atomt	
Para   Gravida:   AB:   LMP:   Marital Status:   Marital Date:	Obs/Gyn Cla	aims								
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 : 36.6  HR : 56  : 18  Assessment/Diagnosis :  Acute  Chronic  Suspected  INDICATE DIAGNOSIS NOT SYMPTOM  Type  Code  Diagnosis  Primary  I10  Essential (primary) hypertension	Para	Gravida:	AD. IMD.		Marital Status	Marital Date:		IVIIVI	11111	
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    1:36.6    HR:56    :18  Assessment/Diagnosis:    Acute    Chronic    INDICATE DIAGNOSIS NOT SYMPTOM  Type    Code    Diagnosis  Primary    I10    Essential (primary) hypertension  Secondary    R51.9    Headache, unspecified	Pala	O Gravida.	AB.	LIVII .	iviarital Status.	iviaritai bate.	$\overline{}$			
OBJECTIVE / ASSESSMENT (To be completed by Physician)  Clinical Findings:  Vital Signs: B/P:123 T:36.6 HR:56 : 18  Assessment/Diagnosis:	What date di	d the Patient first feel s	ame / similar S	Symptom(	s) : dd mm yyyy					
Clinical Findings:  Vital Signs: B/P:123 T:36.6 HR:56  : 18  Assessment/Diagnosis:	Is the Patien	t under any type of Trea	atment? O Ye	es O No	o if yes, indicate what A	ssessment and since	when:			
Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM  Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified	OBJECTIVE	/ ASSESSMENT(To be	completed by	Physicia	n)					
Type Code Diagnosis  Primary I10 Essential (primary) hypertension  Secondary R51.9 Headache, unspecified	Clinical Find	dings :				s: B/P:123	T : 36.6	HR :	56	
Primary I10 Essential (primary) hypertension Secondary R51.9 Headache, unspecified				011101110	○ Confirmed ○ S	uspected				
Secondary R51.9 Headache, unspecified	Туре		Code		Diagnosis					
	Primary		I10		Essential (primary) hype	ential (primary) hypertension				
ACCIDENT/OCCUPATIONAL Claim Information (consulate if plains in a world of period at a world weleted illegate financial	Secondary	,	R51.9		Headache, unspecified					
	ACCIDENT/	OCCUPATIONAL Claim	Informaton	(complet	e if claim is a result of a	ccident or work relat	tad illnass/ini	iury)		

Accident or illness due to work? Injury due to accident?						Describe how the accident or work related injury/illness occur:					
○ Yes ○ No ○ Yes ○				No							
Date of accident or beginni	ing of illn	ess:									
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim											
CPT Code Treatment				Туре				Price			
9 GP Consultation				General Consultation				25.0000			
Code	Generic			Duratio	Ouration Instruction			ns			
No Prescriptions History Fo	ound										
O Pharmacy:		Estmated (	Costs	O Laboratory / Radio		O Laboratory / Radiolog	gy:	Estmated Costs			
		Surger	y:	○ Endoscopy:							
Is the following required O Physiotherap			:herapy:	erapy:		Other Procedures:		1			
						If yes please specify		]			
le In nationt Dequired 2 Lang	th of Cto	,				Indicate Dravider			Fatimata Coat		
Is In-patient Required? Length of Stay  Indicate Provider  Estimate Cost  I hereby certfy that all information mentioned are correct  I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to											
& that the medical services				•		formaton regarding my r			_		
medically indicated & necessary for the management of the						f determining insurance l		edical manag	gement is the sole		
this case.				responsibi	ility	of doctor and the patent.					
Treating Physician Name : H											
Tel / Fax (important):	, ma										
Signature & Stamp											
Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.						nture(Parent if minor)					
Date :				Date : 02							
Note: Claims must be submited along with supportng documents within 30 days from date of service											

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