

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	JULIAN WANGARI WANJIKU	Gender:	Female	Validity Between:	08/05/2024 and 08/02/2025
Card No:	E2D6-5038-06C7-FD94	DOB:	9/2/1982 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1982-5292025-3	Service Date:	04-Jun-2024	Radiology:	Covered
		Patent's Tel No:	0555224198		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43294	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

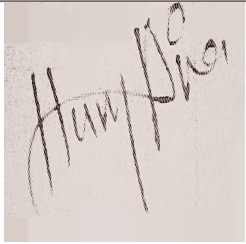
Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
co swelling of the both ankles back pain 4 days								
oe swelling of both ankles pain chest is clear no added sound								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 129 T : 36.5 HR : 64 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	M25.572	Pain in left ankle and joints of left foot					
Secondary	M25.571	Pain in right ankle and joints of right foot					
Secondary	M25.462	Effusion, left knee					

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	
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000	
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000	
86140	C-reactive protein;	Lab	15.0000	
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000	
86431	Rheumatoid factor; quantitative	Lab	20.0000	
9	GP Consultation	General Consultation	25.0000	
Code	Generic	Duration	Instructions	
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)	
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others	
4417-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others	
☐ 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 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 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.	
Treating Physician Name : Humaira			
Tel / Fax (important):			
 Signature & Stamp		 Patient's Signature(Parent if minor)	
			
Date :		Date : 04-Jun-2024	
Note: Claims must be submitted along with supporting documents within 30 days from date of service			

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