eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**MD SAMIM HOSSAIN MOHAMMAD ABUL KASEM TALUKDER**	Gender:	**Male**	Validity Between:	**03/08/2023 and 02/08/2024**
Card No:	**9297-DB4E-A51A-A210**	DOB:	**7/30/1985 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1985-7214243-2**	Service Date:	**05-Jun-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0503728255**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43306**	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 heart burn abdominal pain hair loss on the back side of the head oe epigastric pain hair loss on the temporal region, there is a patch chest is clear no added sounds			

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 : 120	T : 36.6	HR : 84	RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding

Type	Code	Diagnosis
Secondary	R10.13	Epigastric pain
Secondary	L65.9	Nonscarring hair loss, 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:		

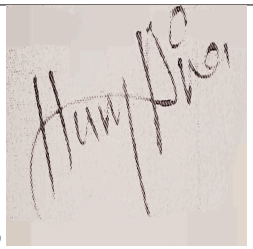
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
86677	Antibody; Helicobacter pylori	Lab	25.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
1233-564801-1171	(PYRIDOXINE (VITAMIN B6) : 2 MG) (VITAMIN B12 : 1 MG) (THIAMINE (VITAMIN B1) : 1.4 MG) (NIACINAMIDE : 18 MG) (BETACAROTENE : 400 MCG) (PHYTONADIONE (VITAMIN K1) : 30 MCG) (VITAMIN E : 10 IU) (BIOTIN : 100 MCG) (CHROMIUM : 40 MCG) (RIBOFLAVINE (VITAMIN B2) : 1.4 MG) (POTASSIUM : 40 MG) (ASCORBIC ACID (VITAMIN C) : 60 MG) (ZINC : 5 MG) (PHOSPHORUS : 125 MG) (SELENIUM : 30 MCG) (MAGNESIUM : 50 MG) (MOLYBDENUM : 50 MCG) TABLETS	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	14	Take 1Tablets 1 Time(s) per Day For 14 Day(s) others

○ 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 : **Humaira**		
Tel / Fax (important):		

Signature & Stamp  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 05-Jun-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

Disclaimer: NEXtCARE ASOAP form is used for claim creaton 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 efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.