

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	Joyce Mukasa	Gender:	Female	Validity Between:	09/02/2024 and 08/02/2025
Card No:	A74D-828E-CED7-E169	DOB:	11/5/1995 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1995-3438894-9	Service Date:	06-Jun-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0561985679		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43319	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
PC: Fever, cough, sorethroat, headache and vomiting								
Duration: 1/06/2024 (6days).								
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 : 110 T : 39.5 HR : 124 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J02.9	Acute pharyngitis, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	R53.1	Weakness					
Secondary	R51.9	Headache, unspecified					
Secondary	M79.10	Myalgia, unspecified site					
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:		

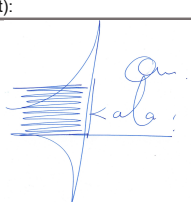
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for	Co.Pay	5.0000

CPT Code	Treatment	Type	Price
	primary procedure)		
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0802	CEFTRIAZONE-TABUK IM-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000

Code	Generic	Duration	Instructions
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal

☐ 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 : Enomen Goodluck		
Tel / Fax (important):		
Signature & Stamp  	Patient's Signature(Parent if minor) 	
Date :	Date : 06-Jun-2024	
Note: Claims must be submitted along with supporting 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.