

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	Gina Subsilica Mapula	Gender:	Female	Validity Between:	09/02/2024 and 08/02/2025
Card No:	2C9C-940D-3483-34EB	DOB:	3/10/1978 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1978-2435294-8	Service Date:	10-Jun-2024	Radiology:	Covered
		Patent's Tel No:	0586467453		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	43334	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
For follow up,							
Still complaint of lower abdominal and low back pain with fever							
WBC shows marked leukocytosis of 23.12 thousands with neutrophilia of 89.2%.							
Urinalysis is suggestive of UTI with blood in urine, ketone in urine, leukocytes in urine, and bacterial in urine.							
CRP is high at 308mg/L							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					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 : 130 : 18	T : 36.8	HR : 76	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected				
INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	N39.0	Urinary tract infection, site not specified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	D72.829	Elevated white blood cell count, unspecified
Secondary	E61.1	Iron deficiency
Secondary	R50.9	Fever, unspecified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

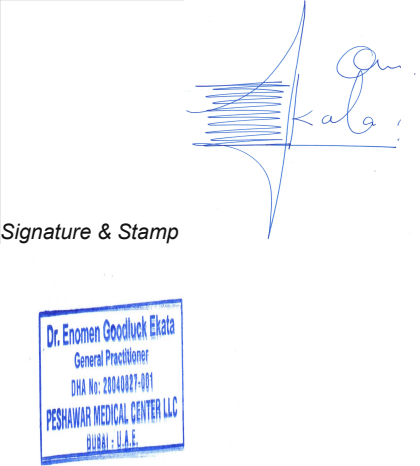
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9.01	Follow-up consultation	General Consultation	0.0000
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 primary procedure)	Co.Pay	5.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
83540	Iron	Lab	20.0000
85060	Blood smear, peripheral, interpretation by physician with written report	Lab	10.0000
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Lab	5.0000

Code	Generic	Duration	Instructions
0137-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) before meal
0067-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
0054-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED 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>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>		
<i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
Signature & Stamp 	Patient's Signature(Parent if minor) 	
Date :	Date : 10-Jun-2024	
Note: Claims must be submitted along with supportng documents within 30 days from date of service		

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