

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	FREDALYN BILAN BAGSAO	Gender:	Female	Validity Between:	09/11/2023 and 08/11/2024
Card No:	9EBF-70AC-9D11-B4EC	DOB:	2/15/1991 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1991-9811531-5	Service Date:	11-Jun-2024	Radiology:	Covered
		Patent's Tel No:	0552811634		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42593	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 FEVER bodyache dizziness pain in throat 5 days								
oe								
high grade fever								
chest is clear no added sounds								
restless								
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 : 100 : 18	T : 38	HR : 94	RR
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM				

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	J02.9	Acute pharyngitis, unspecified
Secondary	R52	Pain, unspecified
Secondary	E86.0	Dehydration

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

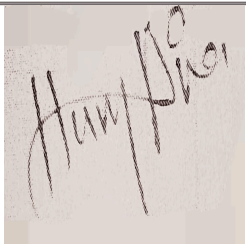
CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0195-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
1516-148602-0391	(CLARITHROMYCIN : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0009-143602-1171	(CEFUROXIME : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	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
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I hereby certify that all informaton mentoned are correct & that the medical services shown on this form were	I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for
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medically indicated & necessary for the management of this case.	the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.
Treating Physician Name : Humaira	
Tel / Fax (important):	
 Signature & Stamp Dr. Humaira Mumtaz General Practitioner DHA No: 54155530-002 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	 Patient's Signature(Parent if minor)
Date :	Date : 11-Jun-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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