

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name: NAJIB FOUAD AMHAZ	Gender: Male	Validity Between: 17/07/2023 and 16/07/2024
Card No: 191A-31D6-2739-59D0	DOB: 3/1/1999 12:00:00 AM	Coverage Informaton for: Out Patient
Pin #:	Identty Card:	Network: RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID: 784-1999-4415019-4	Service Date: 21-Jun-2024	Radiology: Covered
Policy Holder:	Patent's Tel No: 0557609948	
Payer Name: ORIENT INSURANCE P.J.S.C	Threshold Limit:	
	Class: Normal	
	Out-Patent :	
Category: Category B	Patent's File No: 43409	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
PC: Cough, fever, headache, chest pain and wheezing.			YYYY
Duration: since the past 1 week. Wheezing started today.			
Cough is productive of yellow sputum.			
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 : 137 T : 37 HR : 102 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J22	Unspecified acute lower respiratory infection	
Secondary	J20.9	Acute bronchitis, unspecified	
Secondary	R50.9	Fever, unspecified	
Secondary	J06.9	Acute upper respiratory infection, 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	

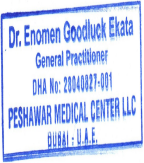
Date of accident or beginning of illness:			
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim			

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
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
0188-135906-2441	PULMICORT	Pharmacy	10.4800
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)	Co.Pay	15.0000

Code	Generic	Duration	Instructions
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	5	Take 10ML 3 Time(s) per Day For 5 Day(s) after meal
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) evening
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) evening
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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 benefits. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		

<i>Signature & Stamp</i> 	<i>Patient's Signature(Parent if minor)</i> 
Date :	Date : 21-Jun-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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