

eASOAP FORM


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

Patent Name:	MAY JANICE GEROZAGA CANAS	Gender:	Female	Validity Between:	27/03/2024 and 26/03/2025
Card No:	5F09-5667-E012-1EE7	DOB:	6/12/1979 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1979-2536057-6	Service Date:	24-Jun-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971557397368		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	28153	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 PC: Recurrent nasal congestion, nasal discharge, cough and severe frontal headache. Duration: 3days. Also has bilateral shoulder pain and generalized body pains that is more at the back.						DD	MM	YYYY
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 : 112 T : 37.1 HR : 80 RR : 20		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J01.10	Acute frontal sinusitis, unspecified			
Secondary	J45.30	Mild persistent asthma, uncomplicated			

Type	Code	Diagnosis
Secondary	R50.9	Fever, unspecified
Secondary	R05	Cough

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:		

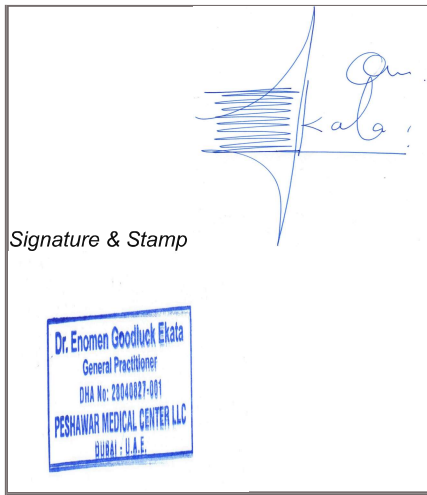
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1021	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	1.7000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 2Tablets 1Time(s) perDay For 5 Day(s) after meal
5253-649501-3851	(MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY	5	Take 2Spray 2 Time(s) per Day For 5 Day(s) others
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	8	Take 1Tablets 3 Time(s) per Day For 8 Day(s) after meal
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
0205-123701-0392	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) evening

☐ 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		

 Signature & Stamp	<i>Patient's Signature(Parent if minor)</i> 
Date :	Date : 24-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 creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.