Laboratory:

Covered

Describe how the accident or work related injury/illness occur:

eASOAP FORM



The member is allowed for **Out Patient ADMINISTRATIVE** at the Irham Medical Center Arjan **MAI CHI ELSAYED** 12/09/2023 and 11/09/2024 Patent Name: Gender: **Female** Validity Between: **KHAMES** 9/2/2019 12:00:00 Coverage Informaton 21A7-3E46-C3C2-00CB Card No: DOB: **Out Patient** ΑM RN UAE (Al Ansari-AUH)-Pin #: **Identty Card:** Network: **MEDGULF** Natonal ID: Service Date: 20-Oct-2023 Radiology: Covered 784-2019-4026169-2 Patent's Tel No: 0558797108 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Normal Payer Name: Class: P.J.S.C Out-Patent: Patent's File 39317 Category: **Category B** Pharmacy: **Co-Part: 20%** No:

Consultation:

No

Gatekeeper:

Referral No: Referred Service:

SUBJECTIVE A	ASSESSMENT										
Symptom(s) as described by the patent (Chief Complaint):							Date	Date of Symptoms/illness started			
Complaint Severe productive cough and wheezing since one week started on 13/10/2023								MM	YYYY		
Post Modical Survival History 2				○ Vos	Yes		Date	Date of Symptoms/illness started			
rast ivieuita	Past Medical Surgical History?						DD	MM	YYYY		
							Date	of Sympton	ns/illness sta	rtod	
Obs/Gyn Clai	ms						DD	MM	YYYY	rteu	
Para	Gravida:	□ АВ:	LMP:	Marital Status	us: Marital Date:						
What date dic	I the Patient first feel sa	I ame / similar S	I Symptom(s)	l) : dd mm yyyy							
Is the Patient	under any type of Trea	tment? O Ye	es O No	if yes, indicate	e what Asse	ssment and since	when:				
OBJECTIVE /	ASSESSMENT(To be	completed by	Physician)								
Clinical Findings :					Vital Signs: B/P:0 T:37.4 HR:100 :24					RR	
Assessment II	/Diagnosis : ○ A NDICATE DIAGNOSIS		Chronic OM	O Confirmed	d OSusp	pected					
Туре		Code		Diagnosis	Diagnosis						
Primary		J20.9 Acute bro			nchitis, unspecified						
Secondary		J01.40 Acu			ute pansinusitis, unspecified						
Secondary		R09.81 Nasal cong			estion						
Secondary		R05		Cough	Cough						
ACCIDENT/C	CCUPATIONAL Claim	Informaton	(complete	if claim is a re	sult of accid	lent or work rela	ted illness/ii	njury)			
Assident or illness due to work?				to road	Describe how the assident an work m			ما انصاب سر را الصر			

accident?

Accident or illness due to work?

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Price Troode Treatment Type Price 10 Specialist Consultation General Consultation 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug): Co. Pay 10,000 96372 Therapeutic prophylactic, or diagnostic injection (specify substance or drug): Co. Pay 10,000 9005-111805- 1021 CHLOROHISTOL 10MG Pharmacy 1,2000 9125-122107- 9122 DEXAMETHASONE SODIUM PHOSPHATE Pharmacy 2,3400 9126-122107- 9122 DEXAMETHASONE SODIUM PHOSPHATE Pharmacy 2,3400 9128-135906- 2441 Pharmacy 10,4800 9006-12413- VENTOUIN NEBULES General Consultation of patient utilization of an serosol generator, nebulizer, Co. Pay 20,0000 9128-135906- 2441 Pharmacy 10,4800 9006-12413- VENTOUIN NEBULES General Consultation Pharmacy 10,4800 9128-135906- 2441 (SALBUTAMOL/AS SULPHATE): 2 MG/SML) SYRUP (SUGAR FREE) 7 Take SML 3 Time(s) per Day For 7 Day(s) others 9128-131020- (CETRIZINE HCL: 1 MG/ML) SOLUTION (ORAL) 7 Take SML 2 Time(s) per Day For 7 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 8 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 7 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML) (AMOXICILLIN: 400 MG/SML) 8 Take SML 2 Time(s) per Day For 7 Day(s) others 9129-131020- (CAVULANIA CAID: 57 MG/SML	○ Yes ○ No			No									
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Is the following required Surgery: Other Procedures: If yes please specify Indicate Provider Indicate P													
Is In-patient Required? Length of Stay Indicate Provider Indicate Pr	Filarifiacy.	O Pharmacy: Estmated Costs				Caboratory / Radiology:							
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Indicate Provider Is In-patient Required? Length of Stay Indicate Provider Indicate Pr	Is the following re	quired	OPhysioth	nerapy:									
I hereby certfy that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Mohammadmahdi Tel / Fax (important): Signature & Stamp Dr. Mohammadmahdi Ghodslehrani Specialist Neonatology DHA No: 0045407-011 PESHAWAR MEDICAL CENTER LLC UBBL-UA.E. I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp Dr. Mohammadmahdi Ghodslehrani Specialist Neonatology DHA No: 0045407-011 PESHAWAR MEDICAL CENTER LLC UBBL-UA.E. Patient's Signature(Parent if minor)						If yes please specify							
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Mohammadmahdi Tel / Fax (important): Signature & Stamp Dr. Mohammadmahdi Ghodstehran Specialist Neonatology DHA NO: 00045407-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor)	Is In-patient Require	ed ? Length of Stay	Indicate Provider					Estimate Cost					
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Signature & Stamp Dr. Mohammadmahdi Ghodslehrani Specialist Neonatology DHA No: 00045407-001 PESHAWAR MEDICAL CENTER LLC DUBAI • U.A.E. Patient's Signature(Parent if minor)		Name : Mohamma	ıdmahdi		,,,								
Dr. Mohammadmahdi Ghodstehrani Specialist Neonatology DHA NO: 00045407-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E. Patient's Signature(Parent if minor)	Tel / Fax (important	:):											
PESHAWAR MEDICAL CENTER LLC DUBAI · U.A.E. Patient's Signature(Parent if minor)	Signature & Stamp Dr. Mohammadmahdi Ghodstehrani Specialist Neonatology												
Patient's Signature(Parent if minor)													
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pate: 20-Oct-2023													
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Note: Claims must be submited 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 final opinion will be given by the NEXtCARE claims doctors.