eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**MUHAMMAD RAFIQ BABOO**	Gender:	**Male**	Validity Between:	**21/12/2022 and 20/12/2023**
Card No:	**2909-2626-C5DF-5236**	DOB:	**1/1/1971 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1971-2197395-8**	Service Date:	**21-Oct-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0555068610**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37836**	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
dry cough running nose fever burning while passing stool(no h/o constipation) hyperpigmented patches on trunk(multiple sites)			

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 : 120	T : 37.4	HR : 88	RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R05	Cough
Secondary	J00	Acute nasopharyngitis [common cold]
Secondary	K62.89	Other specified diseases of anus and rectum
Secondary	B35.4	Tinea corporis

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

Code	Generic	Duration	Instructions
0139-128302-0651	(MUPIROCIN (AS CALCIUM) : 20 MG/G) OINTMENT	10	apply 4 Time(s) per Day For 10 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0207-214402-0151	(BETAMETHASONE : N/A) (CLOTRIMAZOLE : N/A) CREAM	14	Take 1Cream 2 Time(s) per Day For 14 Day(s) others
0290-106307-0081	(ASCORBIC ACID (VITAMIN C) : 100 MG) CHEWABLE TABLETS	14	Take 2Syrup 3 Time(s) per Day For 14 Day(s) after meal
0349-106203-1171	(MULTIVITAMINS : 30 MG) (MINERALS : 30 MG) TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0009-140401-1641	(MICONAZOLE : 2%) DUSTING TOPICAL POWDER	7	Take 1Powder 1 Time(s) per Day For 7 Day(s) others
0307-140201-1451	(FLUCONAZOLE : 150 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 1 Time(s) per Week For 5 Day(s) others
0005-116901-2471	(SODIUM CITRATE : 28.5 MG/5 ML) (MENTHOL : 0.55 MG/5 ML) (DIPHENHYDRAMINE : 7 MG/5 ML) SYRUP (ALCOHOL FREE)	10	Take 10Syrup 3 Time(s) per Day For 10 Day(s) after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 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.	*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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Sajid Sanaullah**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 21-Oct-2023	
Note: Claims must be submited along with supportng 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 fnal opinion will be given by the NEXtCARE claims doctors.