# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **BHAGYA MADHUSHANI JAYAWEERA WADIYA PATHIRENNEHELAGE** | Gender: | **Female** | Validity Between: | **20/02/2023 and 19/02/2024** |
| Card No: | **4ACC-AC14-2CA1-2230** | DOB: | **2/10/1991 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1991-9962322-6** | Service Date: | **21-Oct-2023** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0502457484** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **40153** | 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** | | |
|---|---|---|---|
| | DD | MM | YYYY |
| **Complaint**<br>Pat. came with complaints of sore throat , fever , no chills , pain in swallowing since past 1 day and its getting worse with dry cough .<br>running nose,body pain+<br>On examination : Erythema Heart s1 s2 heard, lungs clear, Abd : no HS megaly , soft. | | | |

| **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 : 130 | T : 37.4 | HR : 88 | RR : 24 |
|---|---|---|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | J06.9 | Acute upper respiratory infection, unspecified |
| Secondary | R07.0 | Pain in throat |
| Secondary | R05 | Cough |
| Secondary | R52 | Pain, unspecified |
| Secondary | J00 | Acute nasopharyngitis [common cold] |

| Type | Code | Diagnosis |
|---|---|---|
| Secondary | K29.00 | Acute gastritis without bleeding |

**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 | CONSULTATION GP | General Consultation | 25.0000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 0005-116801-1161 | (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP | 10 | Take 10ML 3 Time(s) per Day For 10 Day(s) after meal |
| 2572-242802-0341 | (PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS | 10 | Take 1Tablets 1 Time(s) per Day For 10 Day(s) 30 minutes before meal |
| 0186-143703-1451 | (CELECOXIB : 400 MG) CAPSULES (HARD GELATIN) | 10 | Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal |
| 6101-125822-3931 | (POVIDONE IODINE : 2 G/200ML) MOUTHWASH-SOLUTION | 7 | Take 5ML 3 Time(s) per Day For 7 Day(s) after meal |
| 0788-106705-1171 | (CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS | 10 | Take 1Tablets 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 | | |

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