

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MUHAMMAD HAMZA MUHAMMAD JAVED	Gender:	Male	Validity Between:	18/07/2023 and 17/07/2024
Card No:	C747-C9F1-7105-774F	DOB:	10/6/1995 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1995-1921703-0	Service Date:	23-Oct-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0547363682		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	38208	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
Severe upper abdominal pain for the past 3days.								
Pain is worst when hungry and radiates to the back.								
It is also noted to be more severe when he takes coffee.								
Associated with nausea and vomiting and diarrhea.								
Non smoker and does not take alcohol.								
Exam: Ill-looking, dehydrated.								
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 : 110 : 22	T : 36.5	HR : 68	RR
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	R10.13	Epigastric pain
Secondary	R11.2	Nausea with vomiting, 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:		

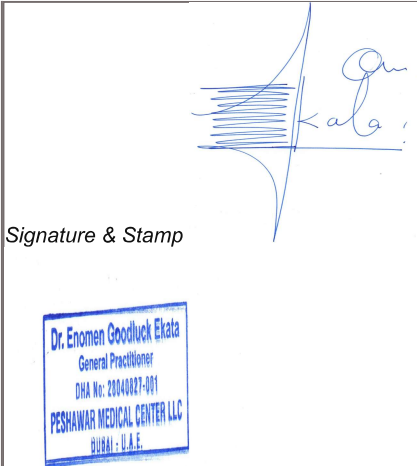
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	CONSULTATION GP	General Consultation	25.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION	Pharmacy	29.5000
0102-152902-1001	LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION	Pharmacy	5.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000

Code	Generic	Duration	Instructions
0005-106601-1171	(PARACETAMOL : 500 MG) TABLETS	5	Take 2Tablets 2 Time(s) per Day For 5 Day(s) before meal
1267-141614-1111	(ALUMINIUM HYDROXIDE : 225 MG/5ML) (SIMETHICONE : 25 MG/5 ML) (MAGNESIUM HYDROXIDE : 200 MG/5ML) SUSPENSION	7	Take 10ML 4 Time(s) per Day For 7 Day(s) before meal
0042-136501-1173	(HYOSCINE : 10 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) before meal
4884-632002-1752	(PANTOPRAZOLE (AS SODIUM SESQUIHYDRATE) : 40 MG) GASTRO-RESISTANT TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) before 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>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	 Patient's Signature(Parent if minor)
Date :	Date : 23-Oct-2023
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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