

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MAHETAB HAMDY ABDULLAH HASSAN	Gender:	Female	Validity Between:	01/01/1900 and 16/08/2024
Card No:	1880-EFD9-646D-5EC7	DOB:	4/20/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
National ID:	784-1987-4441571-6	Service Date:	25-Oct-2023	Radiology:	Covered
		Patent's Tel No:	971547757139		
Policy Holder:		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN & GULF INSURANCE & REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	41026	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
weakness ,body pain since today afternoon								
joint pain+								
nausea+								
fever+								
headache+								
chest pain								
patient feel very tired since today afternoon								
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 : 120 T : 38 HR : 100 RR : 22
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected	
INDICATE DIAGNOSIS NOT SYMPTOM	

Type	Code	Diagnosis
Primary	A49.9	Bacterial infection, unspecified
Secondary	R52	Pain, unspecified
Secondary	R07.9	Chest pain, unspecified
Secondary	R53.1	Weakness
Secondary	R11.0	Nausea
Secondary	R50.9	Fever, unspecified
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:		

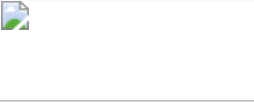
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
96374	IV PUSH	Co.Pay	10.0000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
84550	Uric acid; blood	Lab	15.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2849-100143-0991	5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE-(DEXTROSE : 5% W/V) (SODIUM CHLORIDE : 0.45% W/V) SOLUTION	Pharmacy	5.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
0005-150407-1172	(METOCLOPRAMIDE : 10 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0097-127405-0392	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0669-242801-3261	(PANTOPRAZOLE (AS SODIUM) : 20 MG) DELAYED RELEASE TABLET	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) before meal
0006-106601-0392	(PARACETAMOL : 500 MG) FILM COATED TABLETS	10	Take 1Tablets 3 Time(s) per Day For 10 Day(s) after meal
0278-107902-0391	(IBUPROFEN : 400 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after 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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 25-Oct-2023
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.