## **eASOAP FORM**



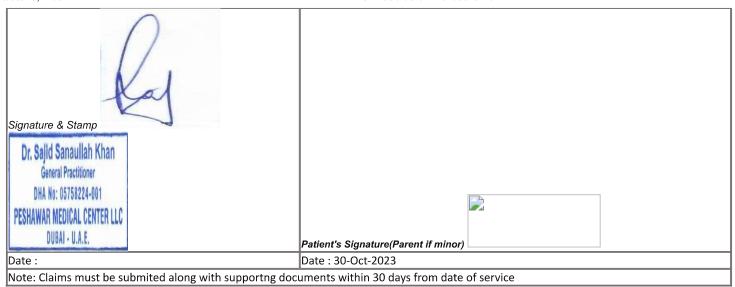
The member is allowed for **Out Patient ADMINISTRATIVE** at the Irham Medical Center Arjan

Patent Name:	ABDEL SATER ABD EL REHIM MOHAMED AHMED	Gender:	Male	Validity Between:	15/08/2023 and 14/08/2024
Card No:	7BDE-2D43-9549-E33F	DOB:	6/12/1971 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1971-9028061-6	Service Date:	30-Oct-2023	Radiology:	Covered
		Patent's Tel No:	505423053		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	31897	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred					
Service:					
SUBJECTIVE ASS	ESSMENT				
Symptom(s) as o	described by the patent (Ch	nief Complaint):			Date of Symptoms/illness started

Complaint							DD	MM	YYYY
Severe cou	igh and sore throat s	since one weel	c and yellov	wish secretio	ns since 20/1	0/2023			
	10 11111 2						Date of	f Symptom	s/illness started
Past Medical Surgical History?				○ Yes		○ No	DD	ММ	YYYY
							D-44	f C t	- /:U
Obs/Gyn Claims					Date of	MM	s/illness started		
☐ Para	Gravida:	□ АВ:	LMP:	Marital Statu	ıs:	Marital Date:		101101	1111
What date did	d the Patient first feel	same / similar :	Symptom(s)	: dd mm yyy	у				
Is the Patient	under any type of Tre	eatment? O Yo	es O No	if yes, indica	te what Asse	ssment and since	when:		
OBJECTIVE	/ ASSESSMENT(To b	e completed by	Physician)						
Clinical Find	lings :				Vital Signs : : 22	B/P:130	T : 37.2	HR:	80 RR
Assessment I	/Diagnosis :		Chronic OM	O Confirm	ed OSusp	ected			
Туре		Code	Diag	gnosis					
Primary		J02.9	Acu	Acute pharyngitis, unspecified					
Secondary		J01.00	Acu	Acute maxillary sinusitis, unspecified					
Secondary		R05	Cou	gh					
	'		·						

Туре	Code	Diagnosis
Secondary	R06.2	Wheezing

ACCIDENT/OCCU	PATIONAL Claim I	nformaton (complete	e if claim is a re	esult of accident or work rel	ated illnes	ss/injury)		
Accident or illnes	s due to work?	Injury du accident?		Describe how the accident or work related injury/illness occur:				
○ Yes ○ No		○ Yes ○	O No					
Date of accident	or beginning of illr	ness:		]				
MEDICAL PLAN II	emized Original In	voices and Applicable	Prescriptions	/ Reports / Results must be	enclosed t	o consider claim		
CPT Code	Treatment					Туре	Price	
9	GP Consultation	1	General Consultation	25.0000				
0005-111805- 1021	CHLOROHISTOL	. 10MG	Pharmacy	1.2000				
0005-149902- 1021	CLOFEN		Pharmacy	6.5000				
0125-122107- 1022	DEXAMETHASC	NE SODIUM PHOSPH	Pharmacy	2.3400				
0195-107704- 0802	CEFTRIAXONE-1	TABUK IM	Pharmacy	48.5000				
0006-124513- 2071	VENTOLIN NEB	ULES	Pharmacy	1.2300				
0188-135906- 2441	PULMICORT		Pharmacy	10.4800				
94664		and/or evaluation of nhaler or IPPB device	Co.Pay	20.0000				
Code	Generic				Duration	Instructions		
0005- 116801- 1161		E : 57 MG/5ML) (AMN NG/5 ML) (DIPHENHY	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others				
0139- 116206- 1171	(CLAVULANIC ACI	D : 125 MG) (AMOXIC	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others				
O Pharmacy: Estmated Costs				O Laboratory / Radiology	: E	Estmated Costs		
		O Surgery:		O Endoscopy:				
Is the following r	equired	O Physiotherapy:		Other Procedures:				
				If yes please specify				
	red ? Length of Star	y mentoned are correct	I haraby auth	Indicate Provider norize any Healthcare Provid	ar Incurar		nate Cost	
, ,,	al services shown o			nformaton regarding my me			-	
		the management of	the purpose of	of determining insurance be				
this case.			responsibility	of doctor and the patent.				
	Name : Sajid Sana	aullah	-					
Tel / Fax (importar	11():							



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