**ADMINISTRATIVE** 

## **eASOAP FORM**



The member is allowed for **Out Patient** 

at the Irham Medical Center Arjan

| Patent Name:         | Kaira Dhiman Abhikant<br>Dhiman | Gender:              | Female                   | Validity Between:        | 05/03/2023 and 04/03/2024          |
|----------------------|---------------------------------|----------------------|--------------------------|--------------------------|------------------------------------|
| Card No:             | 7EB2-8B71-78B9-1F9E             | DOB:                 | 1/26/2019 12:00:00<br>AM | Coverage Informaton for: | Out Patient                        |
| Pin #:               |                                 | Identty Card:        |                          | Network:                 | RN UAE (Al Ansari-AUH)-<br>MEDGULF |
| Natonal ID:          | 784-2019-1379076-8              | Service Date:        | 31-Oct-2023              | Radiology:               | Covered                            |
|                      |                                 | Patent's Tel No:     | 0553092492               |                          |                                    |
| Policy Holder:       |                                 | Threshold<br>Limit:  |                          |                          |                                    |
| Payer Name:          | ORIENT INSURANCE<br>P.J.S.C     | Class:               | Normal                   |                          |                                    |
|                      |                                 | Out-Patent :         |                          |                          |                                    |
| Category:            | Category B                      | Patent's File<br>No: | 41306                    | Pharmacy:                | Co-Part: 20%                       |
| Gatekeeper:          | No                              | Consultaton:         |                          | Laboratory:              | Covered                            |
| Referral No:         |                                 |                      |                          |                          |                                    |
| Referred<br>Service: |                                 |                      |                          |                          |                                    |
| SLIBIFCTIVE ASS      | SESSMENT                        |                      |                          |                          |                                    |

| Symptom(s) as described by the patent (Chief Complaint):   |  |               |  |   |                         |                            | Date o         | Date of Symptoms/illness started |                  |  |
|--|--|---------------|--|---|-------------------------|----------------------------|----------------|----------------------------------|------------------|--|
| Complaint  |  |               |  |   |                         |                            | DD             | MM                               | YYYY             |  |
| severe abdominal p   | ain in suprapub  | oic area sin  | ce three da  | ys and dysuria                                | a since 28/10,          | /2023                      |                |                                  |                  |  |
| Past Medical Surgica   |  | ○ Yes         |  | ○ No  | Date o                  | Date of Symptoms/illnes    |                |                                  |                  |  |
| - use ivicultur surgicu  |  |               |  | 163   |                         |                            | DD             | MM                               | YYYY             |  |
|  |  |               |  |   |                         |                            | Date o         | of Sympton                       | ns/illness start |  |
| Obs/Gyn Claims   |  |               |  |   |                         |                            | DD             | MM                               | YYYY             |  |
| ☐ Para ☐ Gra   | vida:  | ☐ AB:         | LMP:   | Marital Status:                               |                         | Marital Date:              |                |                                  |                  |  |
| What date did the Pati   | ent first feel sar   | me / simila   | r Symptom (:   | s) : dd mm vy                                 | ///V                    |                            |                |                                  |                  |  |
| Is the Patient under ar  |  |               | • • •  |   | • •                     | ssment and since w         | vhen:          |                                  |                  |  |
| OBJECTIVE / ASSESS   | <del>, ,,</del>  |               |  | ,,  |                         |                            |                |                                  |                  |  |
|  |  |               |  |   |                         |                            |                |                                  |                  |  |
|  | VIENI(10 be co   | тргесеа ву    | Pilysiciali)   |   | Vital Signs :           | R/P·O                      | T · 37 1       | HR ·                             | 98               |  |
|  | VIENI(10 be co   | тргесеа бу    | Physician)   |   | Vital Signs :<br>: 22   | B/P:0                      | T:37.1         | HR:                              | 98               |  |
| Clinical Findings :<br>Assessment/Diagnos  |  | te O          | Chronic  | ○ Confirmed                                   | : 22                    |                            | T:37.1         | HR :                             | 98               |  |
| Clinical Findings :<br>Assessment/Diagnos  | is: OAcu   | te O          | Chronic  |   | : 22                    |                            | T : 37.1       | HR:                              | 98               |  |
| Clinical Findings :<br>Assessment/Diagnos<br>INDICATE I  | is : O Acu   | te O          | Chronic<br>M<br>Diagno   | sis   | : 22                    | eted                       | T:37.1         | HR:                              | 98               |  |
| Clinical Findings : Assessment/Diagnos INDICATE [  | is : Acur<br>NAGNOSIS NOT                                      | te O          | Chronic<br>M<br>Diagno   | sis<br>tract infection                        | : 22                    | eted                       | T:37.1         | HR:                              | 98               |  |
| Clinical Findings :  Assessment/Diagnos INDICATE I  Type  Primary  | is: Acurinagnosis not Code                                     | te Or SYMPTOI | Chronic<br>M<br>Diagno   | sis<br>tract infection                        | : 22                    | eted                       | T:37.1         | HR:                              | 98               |  |
| Clinical Findings :  Assessment/Diagnos INDICATE D  Type  Primary  Secondary  Secondary                    | is: AcuriAGNOSIS NOT Code N39.0 R30.0 B35.6                    | te Cresher    | Chronic  V  Diagno  Urinary  Dysuria  Tinea ci                                 | sis<br>rtract infection                       | Suspec                  | ecified                    |                |                                  | 98               |  |
| Clinical Findings :  Assessment/Diagnos INDICATE I  Type  Primary  Secondary  Secondary  ACCIDENT/OCCUPATI | is: AcuriAGNOSIS NOT Code N39.0 R30.0 B35.6                    | te Cresher    | Chronic  V  Diagno  Urinary  Dysuria  Tinea ci                                 | sis rtract infection ruris if claim is a re   | Suspection, site not sp | ecified                    | d illness/inju | ry)                              |                  |  |
| Clinical Findings :  Assessment/Diagnos INDICATE I  Type  Primary  Secondary  Secondary  ACCIDENT/OCCUPATI | is: AcuriAGNOSIS NOT Code N39.0 R30.0 B35.6                    | te Cresher    | Chronic  V  Diagno  Urinary  Dysuria  Tinea co  (complete i                    | rtract infection<br>ruris<br>if claim is a re | Suspection, site not sp | ecified ent or work relate | d illness/inju | ry)                              |                  |  |
| Assessment/Diagnos INDICATE DI Type Primary Secondary Secondary ACCIDENT/OCCUPATI                          | is: AcuriAGNOSIS NOT  Code  N39.0  R30.0  B35.6  ONAL Claim In | te Or SYMPTOI | Chronic  Diagno  Urinary  Dysuria  Tinea ci  (complete i  Injury due accident? | rtract infection<br>ruris<br>if claim is a re | Suspection, site not sp | ecified ent or work relate | d illness/inju | ry)                              |                  |  |

DUBAI - U.A.E.

Date:

| Culture, but the culture of the cult | t Consultation bacterial; quan is, by dip stick or oH, protein, spec roscopy blood, reagent  Generic | cific gravity, urobilinog  | irubin, glucose,  |  |   |  | Type<br>Gene<br>Consu<br>Lab  |  | <b>Price</b> 45.0000 25.0000   |  |
|--|--|--|---|--|---|--|---|--|--|--|
| Culture, but the culture of the cult | bacterial; quan<br>is, by dip stick or<br>iH, protein, spec<br>croscopy<br>blood, reagent<br>Generic | tablet reagent for bili<br>cific gravity, urobilinog   | irubin, glucose,  |  |   |  | Consu   |  |  |  |
| Urinalysis<br>nitrite, pl<br>with micr<br>Glucose;   | is, by dip stick or<br>oH, protein, spec<br>croscopy<br>blood, reagent<br>Generic                    | tablet reagent for bili<br>cific gravity, urobilinog   | irubin, glucose,  |  |   |  | Lab   |  | 25.0000  |  |
| nitrite, pl<br>with micr<br>Glucose;   | oH, protein, spectroscopy blood, reagent Generic   | cific gravity, urobilinog  |   |  |   |  |   |  |  |  |
| 1402-  | Generic  | strip  |   |  | Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy                                |  |   |  |  |  |
|  |  |  |   | Glucose; blood, reagent strip  |   |  |   |  | 10.0000  |  |
|  |  |  |   |  |   |  |   |  |  |  |
|  | /DETABACTILA   |  |   |  | Duration  | Instructions   |   |  |  |  |
| 2002   | 0207-214402- (BETAMETHASONE : N/A) (CLOTRIN CREAM  |  |   |  | 5   | Take 1Cream 3 others   | Time(s) per   | Day For 5 (  | Day(s)   |  |
| (CEFIXIME : 100 MG/5ML) POWDER   |  |  |   | SION   | 5   | Take 5ML 2 Time(s) per Day For 5 Day(s) of   |   |  | (s) others   |  |
| Pharmacy: Estmated Costs   |  |  |   | Caboratory / Radiology: Estr   |   |  | Estmated Co   | osts   |  |  |
| ○ Surgery:   |  |  |   | O End  | Endoscopy:  |  |   |  |  |  |
| s the following required   |  | O Physiotherapy:   |   | Other Procedures:  |   |  |   |  |  |  |
|  |  |  |   | If yes please specify  |   |  |   |  |  |  |
| t Required   | ? Length of Sta  | у  |   | Indicate   | e Provider  |  |   | Estim  | nate Cost  |  |
| medical se<br>ndicated &   | ervices shown o  | n this form were<br>the management of  | to release any<br>the purpose o   | inform<br>f detern   | aton regardi<br>nining insura   | ng my medical co<br>nce benefts. Me  | onditon and   | history to I   | NEXtCARE )   |  |
|  | ame : <b>Mohamm</b> a  | admahdi  |   |  |   |  |   |  |  |  |
| Stamp  |  | th tehrai  |   |  |   |  |   |  |  |  |
| t e rn   | Required strip that a medical so dicated & sician Na portant):  Stamp  Stamp  Andi Ghodstel          | Required? Length of Startfy that all information in medical services shown or dicated & necessary for the isolated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in medical services shown or dicated with the information in the informatio | Required ? Length of Stay refly that all information mentioned are correct medical services shown on this form were dicated & necessary for the management of sician Name: Mohammadmahdi portant):  Stamp  and Ghodslehrani Neonatology | Required ? Length of Stay  rtfy that all informaton mentoned are correct nedical services shown on this form were dicated & necessary for the management of sician Name : Mohammadmahdi portant):  Stamp  Stamp  Andi Ghodstehrani Neonatology | Required ? Length of Stay Indicate rtfy that all informaton mentoned are correct medical services shown on this form were dicated & necessary for the management of sician Name : Mohammadmahdi portant):  Stamp  Stamp  And Chodstehrani Neonatology | Physiotherapy:  Other Procedure If yes please specify  Required? Length of Stay  Indicate Provider  If hereby authorize any Healthcare to release any informaton regardit the purpose of determining insura responsibility of doctor and the pa  Asician Name: Mohammadmahdi portant):  Stamp  Andi Ghodstehrani Neonatology | Required ? Length of Stay  Required ? Length of Stay  Indicate Provider  I hereby authorize any Healthcare Provider, Insure to release any informaton regarding my medical of the purpose of determining insurance benefts. Me responsibility of doctor and the patent.  Sician Name: Mohammadmahdi portant):  Stamp  Stamp | Required Physiotherapy: Other Procedures:  If yes please specify  Required? Length of Stay Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer to release any informaton regarding my medical conditon and the purpose of determining insurance benefts. Medical manageresponsibility of doctor and the patent.  Is ician Name: Mohammadmahdi  Insurance benefts. Medical manageresponsibility of doctor and the patent.  Insurance benefts and the patent | Required ? Length of Stay  Required ? Length of Stay  Indicate Provider  I hereby authorize any Healthcare Provider, Insurer, Employer or other O to release any informaton regarding my medical condition and history to I the purpose of determining insurance benefts. Medical management is the responsibility of doctor and the patent.  Sician Name: Mohammadmahdi portant):  Stamp  And Ghodslehrani Wenatology |  |

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Date: 31-Oct-2023

Note: Claims must be submited along with supporting documents within 30 days from date of service

Patient's Signature(Parent if minor)