Validity Between:

Coverage Informaton

Patent Name:

Card No:

eASOAP FORM

AHMED

HANAE KHIAR YASSIN

BC14-6369-8BBA-08A8



22/08/2023 and 21/08/2024

RN UAE (Al Ansari-AUH)-

Out Patient

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

Female

AM

8/4/1985 12:00:00

Gender:

DOB:

Pin #: Identty C				Card: Network:				MEDGULF			
Natonal ID: Policy Holder:	784-1985-19085	Pat	rvice Date: tent's Tel No reshold	01-Nov-202 : 050701655		Radiology:	Cover	ed			
Policy Holder.	ODIENT INCLID	Lin	nit:								
Payer Name:	ORIENT INSURA P.J.S.C	Cla	iss:	Normal							
Category:	Category B		t-Patent : tent's File :	39749	1	Pharmacy:	Co-Pa	rt: 20%			
Gatekeeper:	No	Co	nsultaton :		1	_aboratory:	Cover	ed			
Referral No: Referred Service:											
SUBJECTIVE AS	SESSMENT s described by the p	actant (Chiaf C	`amplaint\;				Data	f Cumptom	n/illnaga atam		
Complaint	described by the p	batent (Chief C	ompiaini):				Date o	Date of Symptoms/illness started DD MM YYYY			
Also C/o: dul	on review. ertensive controlle I aching pain on bot istory of trauma an	th shoulder joi	nts. Pain is v		morning upo	on waking up.					
Past Medical Surgical History?				Yes	○ No			1	s/illness star	ted	
	,						DD	MM	YYYY	—	
Obs/Gyn Claim							Date o	of Symptom	s/illness star	ted	
						ı	DD	MM	YYYY		
☐ Para	Gravida:	☐ AB:	LMP: M	arital Status:		Marital Date:					
What date did the	ne Patient first feel sa	ame / similar Sv	ymptom(s) : 0	dd mm yyyy		<u> </u>					
	nder any type of Trea				what Asses	sment and since	when:				
OBJECTIVE / A	SSESSMENT(To be	completed by I	Physician)								
Clinical Findin	•	,	, ,		ital Signs : 22	B/P : 138	T:37	HR:	85	RR	
Assessment/D INI	iagnosis : OA			Confirmed	OSusp	ected					
Туре	Code		Diagnos	sis							
Primary	M75.	00	Adhesiv	Adhesive capsulitis of unspecified shoulder							

Rheumatoid arthritis, unspecified

M06.9

Secondary

Туре	Code	Diagnosis
Secondary	M25.519	Pain in unspecified shoulder
Secondary	110	Essential (primary) hypertension
Secondary	Z76.0	Encounter for issue of repeat prescription

508201-0651 G/100G) (WINTERGREEN OIL: 15 G/100G) OINTMENT												
Accident? Yes No No Yes No No No No No No No N	ACCIDENT/OCCU	PATIONA	AL Claim In	formaton	(complete	if claim is a re	sult of accident or wor	k related ill	ness/injury)			
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 9 CONSULTATION GP General Consultation 25.0000 Code Generic 1689- 508201-0651 6/100G) (WINTERGREEN OIL: 15 G/100G) OINTMENT 0027- 149904-0341 1DICLOFENAC SODIUM: 50 MG) ENTERIC COATED TABLETS 1394- (OLMESARTAN MEDOXOMIL: 20 MG) (AMLODIPINE (AS BESYLATE): 5 MG) 618005-0391 FILM COATED TABLETS Strated Costs Orbanarcy: Estmated Costs Surgery: Other Procedures: If yes please specify Indicate Provider Estimated Costs Indicate Provider Indicate Provider Estimated Cost Indicate Provider Indicate Provider Insurer, Employer or other Organizate release any information regarding my medical condition and history to NEXICARE, the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Teating Physician Name: Enomen Goodluck Tel / Fax (important):	ACCIDENT OF HINESS OHE TO WORK?				to road	Describe how the accident or work related injury/illness occur:						
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 Take 1 Cream 3 Time(s) per Day F 508201-0651 G/100G) (WINTERGREEN OIL: 15 G/100G) (INTMENT) O027- 149904-0341 1394- (OLICOFENAC SODIUM: 50 MG) ENTERIC COATED TABLETS DIAMETER (OLIMESARTAN MEDOXOMIL: 20 MG) (AMLODIPINE (AS BESYLATE): 5 MG) 618005-0391 FILM COATED TABLETS Surgery: Estmated Costs Surgery: Dendoscopy: Physiotherapy: Dendoscopy: Dendoscopy: Physiotherapy: Dendoscopy:	○ Yes ○ No				No							
Code Generic General Consultation Duration Instructions	Date of accident	or beginn	nning of illne	ess:								
Code Generic Duration Instructions 1689- 508201-0651 G/100G) (WINTERGREEN OIL: 2 G/100G) (ITURPENTINE OIL: 3 G/100G) (MENTHOL: 5 7 Take 1Cream 3Time(s) perDay F 7 Day(s) others 10027- 149904-0341 (DICLOFENAC SODIUM: 50 MG) ENTERIC COATED TABLETS 5 Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal 1394- 618005-0391 FILM COATED TABLETS 6 Take 1Tablets 1 Time(s) per Day For 56 Day(s) morning Pharmacy: Estmated Costs Surgery: Endoscopy: Physiotherapy: Estmated Costs Surgery: Endoscopy: Physiotherapy: Other Procedures: If yes please specify If yes please specify Is in-patient Required? Length of Stay Indicate Provider Estimate Cost I hereby certfy that all informaton mentoned are correct 8 that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Enomen Goodluck Tel / Fax (important):	MEDICAL PLAN IT	emized C	Original Inv	oices and	Applicable	Prescriptions ,	/ Reports / Results mus	t be enclose	ed to consider	claim		
Code Generic Duration Instructions 1689- 508201-0651 G/100G) (WINTERGREEN OIL: 2 G/100G) (ITURPENTINE OIL: 3 G/100G) (MENTHOL: 5 6/100G) (WINTERGREEN OIL: 15 G/100G) OINTMENT 7 Day(s) others 8 Day(s) others 8 Day(s) others 9 Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Time(s) per Day For So Day(s) others 1 Ake 1Tablets 2 Ti	CPT Code Treatment					Туре		Price				
1689- (EUCALYPTUS OIL : 2 G/100G) (TURPENTINE OIL : 3 G/100G) (MENTHOL : 5 G/100G) (MINTERGREEN OIL : 15 G/100G) OINTMENT Take 1Cream 3Time(s) perDay F 7 Day(s) others	9		CONSULT	TATION GP)		General Consultation		25.0000			
1689- (EUCALYPTUS OIL : 2 G/100G) (TURPENTINE OIL : 3 G/100G) (MENTHOL : 5 G/100G) (MINTERGREEN OIL : 15 G/100G) OINTMENT Take 1Cream 3Time(s) perDay F 7 Day(s) others												
508201-0651 G/100G) (WINTERGREEN OIL: 15 G/100G) OINTMENT / 7 Day(s) others 0027- 149904-0341 (DICLOFENAC SODIUM: 50 MG) ENTERIC COATED TABLETS 5 Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal 1394- 618005-0391 (OLMESARTAN MEDOXOMIL: 20 MG) (AMLODIPINE (AS BESYLATE): 5 MG) 56 Take 1Tablets 1 Time(s) per Day For 56 Day(s) morning O Pharmacy: Estmated Costs	Code	e Generic						Duration	Instructions			
149904-0341 (DILLOPENAL SOUTION : 50 MIG) ENTERIC COATED TABLETS For 5 Day(s) after meal 1394- 618005-0391 FILM COATED TABLETS Estmated Costs Surgery:										Take 1Cream 3Time(s) perDay For 7 Day(s) others		
FILM COATED TABLETS Surgery: Estmated Costs		027- (DICLOFENAC SODILIM : 50 MG) ENTERLI				IC COATED TA	BLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal			
Surgery: Physiotherapy: If yes please specify Indicate Provider 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 certfy that all informaton mentoned are correct that can be included to 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 Organizate release any informaton regarding my medical condition and history to NEXTCARE the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Enomen Goodluck Tel / Fax (important):					AMLODIPINE (
Is In-patient Required? Length of Stay Indicate Provider Indicate Pr	O Pharmacy:		I	Estmated	Costs		O Laboratory / Radio	ology:	Estmated C	Estmated Costs		
Is In-patient Required? Length of Stay Indicate Provider Indicate Pr				O Surger	γ:		○ Endoscopy:					
Is In-patient Required? Length of Stay Indicate Provider 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. Treating Physician Name: Enomen Goodluck Tel / Fax (important): Indicate Provider I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizate release any informaton regarding my medical condition and history to NEXtCARE the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.					Other Procedures:		7					
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 Organizate release any informaton regarding my medical condition and history to NEXtCARE the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Enomen Goodluck Tel / Fax (important):				,	. ,		If yes please specify					
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 Organizate release any informaton regarding my medical condition and history to NEXtCARE the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Treating Physician Name: Enomen Goodluck Tel / Fax (important):	la In nationt Pagui	rod 2 Lon	nath of Stay	,			Indicate Provider			Estimate Cost		
& that the medical services shown on this form were medically indicated & necessary for the management of this case. Treating Physician Name: Enomen Goodluck Tel / Fax (important):					are correct	I hereby auth						
Treating Physician Name : Enomen Goodluck Tel / Fax (important):	& that the medical services shown on this form were				release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole							
Tel / Fax (important):					responsibility of doctor and the patent.							
Lala,												
Dr. Enomen Goodluck Ektata General Practitioner	Dr. Enomen Goodluck Ekata General Practitioner											
PESHAWAR MEDICAL CENTER LLC BURN : JALE. Patient's Signature(Parent if minor)	DHA No. 20440827-001 PESHAWAR MEDICAL CENTER LLC BUBBI : U.A.E.				Patient's Signa							
Date : Date : 01-Nov-2023	Date :				II.							
Note: Claims must be submited along with supportng documents within 30 days from date of service	Note: Claims must be submited along with supportng documer					uments withir	30 days from date of s	service				

Disclaimer: NEXtCARE ASOAP form is used for claim creaton 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 efects 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.