eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**LATA VISHNANI DHARMENDER VISHNANI**	Gender:	**Female**	Validity Between:	**15/03/2023 and 14/03/2024**
Card No:	**114B-A65E-A5A0-D6F1**	DOB:	**6/3/1986 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1986-5875746-7**	Service Date:	**08-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**971506059078**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41392**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):	**Date of Symptoms/illness started**		
Complaint	DD	MM	YYYY
c/o fever, sorethroat and nose block since 2 days c.o of neck pain c/o gastritis O/e- looks ill, throat congested Nasal congestion with b/l turbinate hypertrophy soft, swelling in cervico thoracic region - 4*4 cm, soft, nontender, non mobile swelling Rs- fine crackles present			

Past Medical Surgical History?	○ Yes	○ No	**Date of Symptoms/illness started**		
			DD	MM	YYYY

Obs/Gyn Claims						**Date of Symptoms/illness started**		
						DD	MM	YYYY
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:			

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 : 134 T : 37.6 HR : 77 RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	**Code**	**Diagnosis**
Primary	J06.9	Acute upper respiratory infection, unspecified

Type	Code	Diagnosis
Secondary	R05	Cough
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	R50.9	Fever, unspecified
Secondary	M49.83	Spondylopathy in diseases classd elswhr, cervicothor region
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R09.81	Nasal congestion

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
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates	Lab	25.0000
86140	C-reactive Protein	Lab	15.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0097-142201-0391	(DICLOFENAC POTASSIUM : 50 MG) FILM COATED TABLETS	1	Take 1Tablets 2Time(s) perDay For 1 Day(s) after meal
4235-533801-1751	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) GASTRO-RESISTANT TABLETS	5	Take 1Tablets 5 Time(s) per Day For 5 Day(s) before meal
0553-364604-1071	(ISOTONIC SEA WATER : 27.3% V/V) SPRAY	5	Take 1Spray 4 Time(s) per Day For 5 Day(s) others
0005-108603-2021	(OXYMETAZOLINE HCL : 0.5 MG/ML) NASAL DROPS	3	Take 1Spray 2 Time(s) per Day For 3 Day(s) others
1104-111936-0991	(SODIUM CHLORIDE : 0.9 G/100ML) SOLUTION	5	Take 1Units 2 Time(s) per Day For 5 Day(s) others
6963-819901-1171	(AZITHROMYCIN DIHYDRATE : 500 MG) TABLETS	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 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 Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Dr.Rashmi Mosale**		
Tel / Fax (important):		

 *Signature & Stamp* Dr. Rashmi Keshava Murthy Mosale General Practitioner DHA No: 00230994-003 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 08-Nov-2023
Note: Claims must be submited along with supportng documents within 30 days from date of 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 fnal opinion will be given by the NEXtCARE claims doctors.