eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**MUHAMMAD TANVEER SHAHID MUHAMMAD SIDDIQUE**	Gender:	**Male**	Validity Between:	**22/11/2022 and 21/11/2023**
Card No:	**262D-1DC9-A860-993F**	DOB:	**5/20/1980 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1980-9802631-7**	Service Date:	**11-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0585698711**		
Policy Holder:		Threshold Limit:			
Payer Name:	**MetLife**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41430**	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
severe weight loss 15 kilogram in six months and no appetite since ten days started 1/11/2023 severe constipation also started ten days back					
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 : T : HR : RR :

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R63.4	Abnormal weight loss
Secondary	K59.00	Constipation, unspecified
Secondary	R63.0	Anorexia
Secondary	G47.8	Other sleep disorders
Secondary	Z88.9	Allergy status to unspecified drug/meds/biol subst

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	

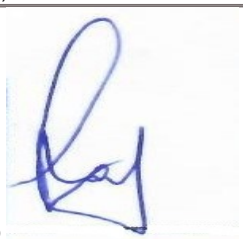
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9	CONSULTATION GP	General Consultation	25.0000
82540	Creatine	Lab	10.0000
84520	Urea nitrogen; quantitative	Lab	10.0000
84450	Transferase; aspartate amino (AST) (SGOT)	Lab	15.0000
84460	Transferase; alanine amino (ALT) (SGPT)	Lab	10.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
82948	Glucose; blood, reagent strip	Lab	10.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000

Code	Generic	Duration	Instructions
0031-168201-0391	(DOMPERIDONE : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0248-170802-1161	(LACTULOSE : 65%) SYRUP	10	Take 10ML 3 Time(s) per Day For 10 Day(s) others
0205-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0321-100604-1171	(VITAMIN B12 : 200 MCG) (THIAMINE (VITAMIN B1) : 100 MG) (PYRIDOXINE (VITAMIN B6) : 200 MG) TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)

○ 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 benefits. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Sajid Sanaullah**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 11-Nov-2023	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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