

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	ODAI AHMAD KHALIL	Gender:	Male	Validity Between:	09/02/2023 and 08/02/2024
Card No:	2175-8697-4AD4-032F	DOB:	7/26/1999 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1999-1527900-6	Service Date:	13-Nov-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0509952621		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	41410	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
respiratory distress and severe wheezing and cough have increased								
severe cough and wheezing since 5/11/2023								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						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 : 120 T : 36.8 HR : 82 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J18.0	Bronchopneumonia, unspecified organism					
Secondary	R06.2	Wheezing					
Secondary	R05	Cough					

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
9.02	9.02 - (9.02) - Follow-up consultation - (AED 0.0000)	General Consultation	0.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800
0006-124513-2071	VENTOLIN NEBULES	Pharmacy	1.2300
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	Co.Pay	20.0000
86140	C-reactive Protein	Lab	15.0000
85651	Sedimentation rate, erythrocyte; non-automated	Lab	10.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
Code	Generic	Duration	Instructions
1401-395404-0391	(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS	15	Take 1Tablets 1 Time(s) per Day For 15 Day(s) others
0015-101502-0271	(ACETYLCYSTEINE : 600 MG) EFFERVESCENT TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others
0030-183202-0391	(FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS	8	Take 1Tablets 2 Time(s) per Day For 8 Day(s) others
1393-412002-1392	(FLUTICASONE PROPIONATE : 250 MCG/DOSE) (SALMETEROL (AS XINAFOATE) : 25 MCG/DOSE) AEROSOL INHALER	10	Take 2Puff 4 Time(s) per Day For 10 Day(s) others
☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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>	<i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>	
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 13-Nov-2023
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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