eASOAP FORM



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

Patent Name:	MAJEDAH EBRAHIM NOUFAL	Gender:	Female	Validity Between:	15/09/2023 and 14/09/2024					
Card No:	CEAA-1E49-0FF2-66F5	DOB:	1/6/1984 12:00:00 AM	Coverage Informaton for:	Out Patient					
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF					
Natonal ID:	784-1984-2367591-1	Service Date:	15-Nov-2023	Radiology:	Covered					
		Patent's Tel No:	971561484427							
Policy Holder:		Threshold Limit:								
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal							
		Out-Patent :								
Category:	Category B	Patent's File No:	41467	Pharmacy:	Co-Part: 20%					
Gatekeeper:	No	Consultaton :		Laboratory:	Covered					
Referral No:										
Referred										
Service:										
SUBJECTIVE ASS	SUBJECTIVE ASSESSMENT									
Symptom(s) as	described by the patent (Cl	nief Complaint):			Date of Symptoms/illness started					

							Date o	Date of Symptoms/illness started			
Complaint						DD	MM	YYYY			
Severe flank pain and high fever and dysuria since two days started on 13/11/2023											
\severe p	ain in suprapubic	area and both fla	inks								
Dast Medic	al Surgical History	,2		Vos		○ No	Date o	Date of Symptoms/illness started			
Past Medical Surgical History?				l o ies		O NO	DD	MM	YYYY		
							Date o	of Symptom	s/illness started		
Obs/Gyn C	laims						DD	MM	YYYY		
Para	☐ Gravida:	□ АВ:	LMP:	Marital Status	s: r	Marital Date:					
			<u> </u>	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
	lid the Patient first f										
Is the Patiei	nt under any type o	f Treatment?	res \bigcirc No	if yes, indicat	e what Assess	sment and since w	/nen:				
OBJECTIVE	/ ASSESSMENT	To be completed b	y Physician))							
Clinical Fin	diam.										
Ollincai i ii	idings :				Vital Signs: B : 22	3/P : 124	T : 36.8	HR:	86 R		
	nt/Diagnosis : INDICATE DIAGN		Chronic TOM	○ Confirme	: 22		T:36.8	HR:	86 R		
	nt/Diagnosis :			○ Confirme	: 22		T:36.8	HR:	86 R		
Assessmei	nt/Diagnosis :	OSIS NOT SYMP	Diagno	○ Confirme	: 22		T:36.8	HR:	86 R		
Assessme	nt/Diagnosis : INDICATE DIAGN	OSIS NOT SYMP	Diagno Acute p	○ Confirme	: 22 d OSuspe	ected	T:36.8	HR:	86 R		
Assessment Type Primary	nt/Diagnosis : INDICATE DIAGN	Code N10	Diagno Acute p	○ Confirme osis pyelonephritis	: 22 d OSuspe	ected	T:36.8	HR:	86 R		
Type Primary Secondar Secondar	nt/Diagnosis : INDICATE DIAGN	Code N10 N39.0 R50.9	Diagno Acute p Urinary Fever, p	Confirme osis pyelonephritis y tract infection unspecified	d Suspe	cified			86 R		
Type Primary Secondar Secondar	nt/Diagnosis : INDICATE DIAGN Y	Code N10 N39.0 R50.9	Diagno Acute p Urinary Fever, p	Confirme pyelonephritis y tract infection unspecified if claim is a re	d Suspe	cified	d illness/injı	ury)			
Type Primary Secondar Secondar	nt/Diagnosis: INDICATE DIAGN Y Y COCCUPATIONAL Or illness due to wo	Code N10 N39.0 R50.9	Diagno Acute p Urinary Fever, u (complete	Confirme osis pyelonephritis y tract infection unspecified e if claim is a re	d Suspe	cified	d illness/injı	ury)			
Type Primary Secondar Secondar ACCIDENT, Accident o	nt/Diagnosis: INDICATE DIAGN Y Y COCCUPATIONAL Or illness due to wo	Code N10 N39.0 R50.9 Claim Informator	Acute purinary Fever, purinary Complete Injury due accident?	Confirme osis pyelonephritis y tract infection unspecified e if claim is a re	d Suspe	cified	d illness/injı	ury)			

Treating Physician Name : Sajid Sanaullah fel / Fax (important):	15/23, 3.49 PW				JIIIICSOIL 6.U	Homouro					
BIODI Biodores, mitre, phy points, posting capacity involving ducrose, homoglobin, lectones. Lab 8.0000 86140 C-reactive Protein Lab 15.0000 85551 Sedimentation rate, erythrocyte; non-automated Lab 10.0000 85552 Blood count, complete (CBCI, automated Higb, Hct, RBC, WBC and platelet count) and Lab 20.0000 85502 Blood count, complete (CBCI, automated Higb, Hct, RBC, WBC and platelet count) and Lab 20.0000 85603 Intravenous infusion, for therapy, prophylaxis, or diagnostic higection (specify substance or drug); intravenous Co. Pay 40.0000 85636 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85636 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85636 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85636 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85636 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85637 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify substance or drug); intravenous Co. Pay 40.0000 85639 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify Pharmacy 45.5000 85630 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify Pharmacy 45.5000 85630 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify Pharmacy 45.5000 86640 Intravenous infusion, for therapy, prophylaxis, or diagnostic specify Pharmacy 45.5000 86640 Intravenous	CPT Code	Treatment						Ту	/pe	Price	
Beukocytes, Intrite, pH, protein, specific gravity, urobilinogen, any number of these Lab 8.0000	87086	Culture, bacterial;	quantitative colony co	ount, urine				La	ab	25.0000	
Sedimentation rate, erythrocyte; non-automated Lab 10,0000	81001 I	leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these					La	ab	8.0000		
Blood count; complete (SRC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count automated differential differential differential wBC count automated differential different	86140	C-reactive Protein						La	ab	15.0000	
automated differential WBC count Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous posh, single or initial substance/orgue posh single or initial substance/orgue posh single or initial substance/orgue posh single orgue posh single or initial substance/orgue posh single or initial substance/orgue posh single orgue posh single orgue posh single or initial substance/orgue posh single orgue posh single o	85651	Sedimentation rate	e, erythrocyte; non-au	tomated				La	ab	10.0000	
possis intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour consistance, for the property of the pr							La	ab	20.0000		
up to 1 hour Cost							Co	o.Pay	10.0000		
149902- 107704- 10770							tial, Co	o.Pay	40.0000		
107704- 00801 0102- 100104 0707- 100104 9 CONSULTATION GP Code Generic 4417-711202- 0816-71202- 0816-	149902-							Pł	narmacy	6.5000	
SODIUM CHLORIDE & DEXTROSE B.P. Pharmacy 4.5000	107704-	CEFTRIAXONE-TAB					Pł	narmacy	48.5000		
Code Generic 4417-711202- 0391 TABLETS (IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED 6 Take 1Tablets 4 Time(s) per Day For 6 Day(s) others 3086-246101- 1171 (PHENAZOPYRIDINE HCL : 100 MG) TABLETS 10 Take 1Tablets 3 Time(s) per Day For 10 Day(s) others 0097-103201- 0391 (CIPROFLOXACIN : 500 MG) FILM COATED TABLETS 5 Take 1Tablets 2 Time(s) per Day For 5 Day(s) others others 10 Take 1Tablets 2 Time(s) per Day For 5 Day(s) others Take 1Tablets 2 Time(s) per Day For 5 Day(s) others 10 Pharmacy: Estmated Costs Surgery: Physiotherapy: Physiotherapy: Other Procedures: If yes please specify Indicate Provider Indicate Provider Estimate Cost I hereby certfy that all information mentoned are correct to that the medical services shown on this form were enedically indicated & necessary for the management of his cose. Thereby certfy that all information mentoned are correct to the that the medical services shown on this form were enedically indicated & necessary for the management of his cose. Thereby certfy that all information mentoned are correct to the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Thereby certfy that all information mentoned are correct to the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Thereby certfy that all information mentoned are correct to the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Thereby certfy that all information mentoned are correct to the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent. Thereby certfy that all information mentoned are correct to the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patent.	100104-	SODIUM CHLORIDE & DEXTROSE B.P.					Pł	narmacy	4.5000		
A417-711202-	9 (CONSULTATION GP							25.0000		
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1171 (CIPROFLOXACIN: 500 MG) FILM COATED TABLETS Others Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others Take 1 Tablets 2 Time(s) per Day For 5 Day(s) others Strate 1 Tablets 2 Time(s) per Day For 5 Day(s) others It leads on the follows: If yes please specify Indicate Provider Estimate Cost Indicate Provider Indicate Provi			AS L-ARGININE SALT) :	h h							
Others Surgery: Estmated Costs Cother Procedures:	(PHENA/OPVRIDINE HOL: 100 MG)			TABLETS	IABLETS			ets 3 Time	3 Time(s) per Day For 10 Day(s)		
Surgery: Surgery: Charles Procedures:	(CIPROFLOXACIN 500 MG) FILM CO			AIFI) IABIFIS 5			ets 2 Time	Time(s) per Day For 5 Day(s)			
Se In-patient Required? Length of Stay Indicate Provider Indicate	O Pharmacy:		Estmated Costs	O Laboratory / Radiology: Estm			Estmated	d Costs			
If yes please specify so in-patient Required ? Length of Stay Indicate Provider Ind			O Surgery:	○ Endoscopy:							
Indicate Provider Estimate Cost I hereby certfy that all informaton mentoned are correct I hereby certfy that all informaton mentoned are correct I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization trelease any information regarding my medical condition and history to NEXTCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Freating Physician Name: Sajid Sanaullah Fiel / Fax (important): Signature & Stamp Dr. Sajid Sanaullah Khan General Practitioner DHANIS 15751224-001 PESHANIR MEDICAL CENTER LLC DUBAL-U.A.E. Patient's Signature(Parent if minor)	s the following re	equired	O Physiotherapy:	Other Procedures:			1				
I hereby certfy that all informaton mentoned are correct to that the medical services shown on this form were nedically indicated & necessary for the management of his case. Treating Physician Name: Sajid Sanaullah red / Fax (important): Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAN MEDICAL CENTER LLC DUBAL-U.A.E. Patient's Signature(Parent if minor) I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any informaton regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefts. Medical management is the sole responsibility of doctor and the patent. Signature & Stamp Patient's Signature(Parent if minor)				If yes please specify				<u> </u>			
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medically indicated & necessary for the management of this case. Treating Physician Name: Sajid Sanaullah Tel / Fax (important): Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLO DUBAL-U.A.E. Patient's Signature (Parent if minor)				I hereby auth			ovider, Insure	er, Employ			
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Signature & Stamp Dr. Salid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAL-U.A.E. Patient's Signature(Parent if minor)	nealcally malcate his case.	a & necessary jor	the management of					eaicai mai	nugement is th	ie soie	
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Date . 13-1104-2023											
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Note: Claims must be submited along with supporting 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 final opinion will be given by the NEXtCARE claims doctors.