eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**SHAH ZADA KHAN GUL NABI**	Gender:	**Male**	Validity Between:	**01/02/2023 and 31/01/2024**
Card No:	**AE82-C7F2-0DC1-9A67**	DOB:	**7/10/1964 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1964-4386065-3**	Service Date:	**15-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0564047039**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41468**	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**		
	DD	MM	YYYY
Complaint No blood sugar or Hgb A1C report available acid uric? Known case of Diabetes type two came with left foot and right foot pain pain and anesthesia since two weeks back started 1/11/2023			

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	E11.9	Type 2 diabetes mellitus without complications
Secondary	M1A.9XX0	Chronic gout, unspecified, without tophus (tophi)
Secondary	E11.8	Type 2 diabetes mellitus with unspecified complications
Secondary	M54.40	Lumbago with sciatica, unspecified side
Secondary	E78.5	Hyperlipidemia, unspecified

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
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
84460	Transferase; alanine amino (ALT) (SGPT)	Lab	10.0000
84450	Transferase; aspartate amino (AST) (SGOT)	Lab	15.0000
82540	Creatine	Lab	10.0000
84520	Urea nitrogen; quantitative	Lab	10.0000
84550	Uric acid; blood	Lab	15.0000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
7070-149919-0431	(DICLOFENAC SODIUM : 1 G/100G) GEL	7	Take 1Gel 3 Time(s) per Day For 7 Day(s) others
0321-164102-2191	(METFORMIN HCL : 1000 MG) PROLONGED RELEASE 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 benefts. 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 : 15-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.