

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	GENET MELKA ASFAW	Gender:	Female	Validity Between:	04/01/2023 and 03/01/2024
Card No:	87F8-E60C-8EC1-8E7B	DOB:	8/16/1978 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1978-5275191-2	Service Date:	23-Nov-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0501750282		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	38075	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
back pain has from 3 week and has history of hyper lipedema and anemia								
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started		
						DD	MM	YYYY
Obs/Gyn Claims				Date of Symptoms/illness started				
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:	DD	MM	YYYY
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 : 139 T : 36.8 HR : 83 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	D64.9	Anemia, unspecified					
Secondary	E78.2	Mixed hyperlipidemia					
Secondary	R25.2	Cramp and spasm					
Secondary	J02.9	Acute pharyngitis, unspecified					
Secondary	R53.1	Weakness					

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
82310	Calcium; total	Lab	10.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
82607	Cyanocobalamin (Vitamin B-12);	Lab	50.0000
84478	Triglycerides	Lab	15.0000
82465	Cholesterol, serum or whole blood, total	Lab	10.0000
83721	Lipoprotein, direct measurement; LDL cholesterol	Lab	15.0000
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	Lab	15.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
No Prescriptions History Found			
☐ 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 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 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 benefets. 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 : 23-Nov-2023	
Note: Claims must be submitted 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 fnal opinion will be given by the NEXtCARE claims doctors.