eASOAP FORM

NEXtCARE® Your Health Managed with Care

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

Patent Name:	**DANIEL MURIUKI MUKUHA**	Gender:	**Male**	Validity Between:	**31/03/2023 and 30/03/2024**
Card No:	**D76A-1A1D-DF39-F76A**	DOB:	**8/22/1974 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1974-7297515-6**	Service Date:	**26-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**971552604518**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41598**	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
stomach pain at night from 20/11/2023								
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 : 139 T : 35.6 HR : 65 RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Secondary	K52.9	Noninfective gastroenteritis and colitis, unspecified
Secondary	R10.819	Abdominal tenderness, unspecified site
Primary	N39.0	Urinary tract infection, site not specified

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
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
9	CONSULTATION GP	General Consultation	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
87086	Culture, bacterial; quantitative colony count, urine	Lab	25.0000

Code	Generic	Duration	Instructions
0207-632002-1751	(PANTOPRAZOLE (AS SODIUM SESQUIHYDRATE) : 40 MG) GASTRO-RESISTANT TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
3114-482003-0391	(CIPROFLOXACIN (AS HYDROCHLORIDE) : 500 MG) FILM COATED TABLETS	25	Take 1Tablets 2 Time(s) per Day For 25 Day(s) others

○ 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 Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 26-Nov-2023
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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