eASOAP FORM

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

Patent Name:	**WARDA SHAFIK TAWFIK IBRAHIM**	Gender:	**Female**	Validity Between:	**20/02/2023 and 19/02/2024**
Card No:	**9240-80CD-9BDC-75E9**	DOB:	**2/1/1993 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1993-8618895-9**	Service Date:	**26-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0565410545**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40869**	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
complains of severe pain abdomen, upper abdomen pain, epigastric- severe since morning. complains of back pain,right side, known case of constipation and colitis in the past before conceiving. G2 p1 L1- 16 weeks pregnancy. per abdomen- uterus 16 weeks size. bp- 130/75, no headache, vomiting. per abdomen- tenderness in right lumbar region. ?? cholecystitis. refer to hospital for surgeon review.			

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 : 125 T : 36.8 HR : 80 RR : 21

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	Z3A.16	16 weeks gestation of pregnancy
Secondary	R10.30	Lower abdominal pain, 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
96374	IV PUSH	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION	Pharmacy	29.5000
10	Specialist Consultation	General Consultation	45.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
81000	URINE ROUTINE EXAMINATION	Lab	5.0000

Code	Generic	Duration	Instructions
1513-242802-0801	(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INJECTION	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
6108-106618-1021	(PARACETAMOL : 10 MG/ML) SOLUTION FOR INJECTION	1	Take 1Tablets 1 Time(s) per Day For 1 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 : **DR. BUSHRA NAYMAT**	
Tel / Fax (important):	

Signature & Stamp  	 ***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	

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.