eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**MUHAMMAD AMIN MUHAMMAD IQBAL**	Gender:	**Male**	Validity Between:	**29/08/2023 and 28/08/2024**
Card No:	**4E45-5ADF-3AC3-2A61**	DOB:	**12/15/1992 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1992-2141985-8**	Service Date:	**29-Nov-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0527580647**		
Policy Holder:		Threshold Limit:			
Payer Name:	**UNITED INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41647**	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
C/o: Cough, fever, chest pain, low back pain and weakness. A known asthmatic previously being managed in another private clinic. His current medications are montelukast, symbicort and pulmicort. Also has long standing history of dyspepsia and chest burn.			

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 : 126	T : 37.2	HR : 87	RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J45.31	Mild persistent asthma with (acute) exacerbation
Secondary	J20.9	Acute bronchitis, unspecified

Type	Code	Diagnosis
Secondary	J22	Unspecified acute lower respiratory infection
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis
Secondary	M54.5	Low back pain
Secondary	M47.896	Other spondylosis, lumbar region

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
9	CONSULTATION GP	General Consultation	25.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
96374	IV PUSH	Co.Pay	10.0000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0006-124513-2071	VENTOLIN NEBULES	Pharmacy	1.2300
0188-135906-2441	PULMICORT	Pharmacy	10.4800
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	Co.Pay	15.0000

Code	Generic	Duration	Instructions
0006-102402-1171	(ACYCLOVIR : 400 MG) TABLETS	30	Take 1Tablets 3 Time(s) per Day For 30 Day(s) after meal
0041-102403-0151	(ACYCLOVIR : 5%) CREAM	30	Take 1Cream 2 Time(s) per Day For 30 Day(s) others
0188-135907-2441	(BUDESONIDE : 0.25 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Puff 2 Time(s) per Day For 60 Day(s) others
0188-272103-0791	(BUDESONIDE : 160 MCG) (FORMOTEROL FUMARATE : 4.5 MCG) POWDER FOR INHALATION	60	Take 1Puff 3 Time(s) per Day For 60 Day(s) others
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal

Code	Generic	Duration	Instructions
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	60	Take 1sachet 1 Time(s) per Day For 60 Day(s) before meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	30	Take 1sachet 3 Time(s) per Day For 30 Day(s) after meal
0281-158901-0652	(BETAMETHASONE : 0.5 MG/G) (CALCIPOTRIOL : 50 MCG/G) OINTMENT	60	Take 1Gel 2 Time(s) per Day For 60 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 : **Enomen Goodluck**		
Tel / Fax (important):		
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 2004087-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 29-Nov-2023	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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