eASOAP FORM

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

Patent Name:	**AFNAN KHAN ZAHOOR KHAN**	Gender:	**Male**	Validity Between:	**07/11/2023 and 06/11/2024**
Card No:	**9C07-49F1-A855-1A98**	DOB:	**1/1/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1982-1813048-6**	Service Date:	**07-Dec-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0555825995**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41749**	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
severe stomach pain and H pylori positive since last month started 5/11/2023 severe stomach pain since today			

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 : 116	T : 36.9	HR : 65	RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	G54.0	Brachial plexus disorders
Secondary	M62.838	Other muscle spasm
Secondary	T78.40XA	Allergy, unspecified, initial encounter

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:		

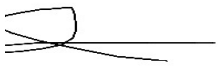
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-150403-1021	PREMOSAN	Pharmacy	0.9000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	10	Take 1Tablets 3 Time(s) per Day For 10 Day(s) others
0009-149901-0291	(DICLOFENAC SODIUM : 1%) EMULGEL	7	Take 1Gel 3 Time(s) per Day For 7 Day(s) others
0031-168201-0391	(DOMPERIDONE : 10 MG) FILM COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others
0669-242802-3261	(PANTOPRAZOLE (AS SODIUM) : 40 MG) DELAYED RELEASE TABLET	14	Take 1Tablets 2 Time(s) per Day For 14 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  	 ***Patient's Signature(Parent if minor)***
Date :	Date : 07-Dec-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.