# eASOAP FORM

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

| | | | | | |
|---|---|---|---|---|---|
| Patent Name: | **SUBHASH CHANDER** | Gender: | **Male** | Validity Between: | **07/06/2023 and 06/06/2024** |
| Card No: | **A8FB-749C-BF85-FE7C** | DOB: | **7/1/1957 12:00:00 AM** | Coverage Informaton for: | **Out Patient** |
| Pin #: | | Identty Card: | | Network: | **RN UAE (Al Ansari-AUH)-MEDGULF** |
| Natonal ID: | **784-1957-3882764-1** | Service Date: | **09-Dec-2023** | Radiology: | **Covered** |
| | | Patent's Tel No: | **0585601705** | | |
| Policy Holder: | | Threshold Limit: | | | |
| Payer Name: | **ORIENT INSURANCE P.J.S.C** | Class: | **Normal** | | |
| | | Out-Patent : | | | |
| Category: | **Category B** | Patent's File No: | **41775** | 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 |
| Has the same history a few months ago improved with medicine | | | | | |
| Severe abdominal distension and vomiting since three days back on 6/12/2023 | | | | | |
| **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 : 144 T : 36.5 HR : 114 RR : 22 |
|---|---|

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

**INDICATE DIAGNOSIS NOT SYMPTOM**

| Type | Code | Diagnosis |
|---|---|---|
| Primary | K29.00 | Acute gastritis without bleeding |
| Secondary | R11.2 | Nausea with vomiting, unspecified |
| Secondary | R14.3 | Flatulence |

| **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 |
| 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 |
| 96361 | Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure) | Co.Pay | 3.0000 |
| 0005-150403-1021 | PREMOSAN | Pharmacy | 0.9000 |
| 0102-152902- | LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION | Pharmacy | 5.0000 |

| CPT Code | Treatment | Type | Price |
|---|---|---|---|
| 1001 | | | |
| 0005-242802-0781 | PANTONIX 40MG I.V. | Pharmacy | 29.5000 |
| 9 | CONSULTATION GP | General Consultation | 25.0000 |

| Code | Generic | Duration | Instructions |
|---|---|---|---|
| 6916-777501-0082 | (DIMETHICONE : 50 MG) (MAGNESIUM HYDROXIDE : 250 MG) (ALUMINIUM HYDROXIDE : 250 MG) (MAGNESIUM ALUMINIUM SILICATE : 50 MG) CHEWABLE TABLETS | 5 | Take 1Tablets 3 Time(s) per Day For 5 Day(s) others |
| 1291-170801-1161 | (LACTULOSE : 66.7%) SYRUP | 7 | Take 20ML 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 |
| 4884-632002-1751 | (PANTOPRAZOLE (AS SODIUM SESQUIHYDRATE) : 40 MG) GASTRO-RESISTANT TABLETS | 7 | Take 1Tablets 2 Time(s) per Day For 7 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*<br>  <br>  | ***Patient's Signature(Parent if minor)***<br>  |
| Date : | Date : 09-Dec-2023 |
| Note: Claims must be submited along with supportng documents within 30 days from date of service | |

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