

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	DIXON DISRENT DISRENT	Gender:	Male	Validity Between:	01/01/1900 and 07/08/2024
Card No:	7F22-E29C-FE5C-3B8E	DOB:	12/30/1987 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1987-9527476-4	Service Date:	13-Dec-2023	Radiology:	Covered
		Patent's Tel No:	971554348432		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	41833	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 cough and sneezing and high fever and body pain for three days started on 10/12/2023 and productive cough and wheezing started today								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						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 : 128		T : 36.8		HR : 102		RR : 22	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	J02.9	Acute pharyngitis, unspecified									
Secondary	J20.9	Acute bronchitis, unspecified									
Secondary	R06.2	Wheezing									
Secondary	R50.9	Fever, unspecified									
Secondary	R09.81	Nasal congestion									

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	
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	
9	GP Consultation	General Consultation	25.0000	
0006-124513-2071	VENTOLIN NEBULES	General Consultation	1.2300	
0188-135906-2441	PULMICORT	Pharmacy	10.4800	
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	Co.Pay	20.0000	
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000	
0005-149902-1021	CLOFEN	Pharmacy	6.5000	
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000	
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000	
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400	
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.	Pharmacy	4.5000	
Code	Generic	Duration	Instructions	
0005-116801-1161	(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others	
0006-402804-2481	(SALBUTAMOL(AS SULPHATE) : 2 MG/5ML) SYRUP (SUGAR FREE)	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others	
0252-389802-1171	(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS	5	Take 1Tablets 4 Time(s) per Day For 5 Day(s) others	
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others	
☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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>	<i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : Sajid Sanaullah	
Tel / Fax (important):	
 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 13-Dec-2023
Note: Claims must be submitted 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.