eASOAP FORM

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

Patent Name:	**JAD SAMER KANNOUT**	Gender:	**Male**	Validity Between:	**16/11/2023 and 15/11/2024**
Card No:	**B62D-4D67-51F1-9840**	DOB:	**12/20/2016 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2016-7107943-8**	Service Date:	**16-Dec-2023**	Radiology:	**Covered**
		Patent's Tel No:	**0507740340**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**37828**	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
mouth aphtus					
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 : 0 T : 36.9 HR : 106 RR : 26

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K12.0	Recurrent oral aphthae
Secondary	B37.0	Candidal stomatitis

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
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
6995-222102-	(NYSTATIN : 100000 IU/ML) SUSPENSION	5	Take 10ML 3 Time(s) per Day

Code	Generic	Duration	Instructions
1111			For 5 Day(s) others
0005-116702-2481	(DIPHENHYDRAMINE : 12.5 MG/5ML) SYRUP (SUGAR FREE)	5	Take 5ML 3 Time(s) per Day For 5 Day(s) others
1389-416601-1171	(PANTOTHENIC ACID (VITAMIN B5) : 20 MG) (ZINC : 15 MG) (CYSTEINE : 40 MG) (CARNITINE : 30 MG) (BETACAROTENE : 3 MG) (IRON : 8 MG) (RIBOFLAVINE (VITAMIN B2) : 6 MG) (CHROMIUM : 100 MCG) (VITAMIN B12 : 14 MCG) (FOLIC ACID : 500 MCG) (THIAMINE (VITAMIN B1) : 18 MG) (NIACIN (VITAMIN B3; NICOTINIC ACID) : 27 MG) (PYRIDOXINE (VITAMIN B6) : 10 MG) (ASCORBIC ACID (VITAMIN C) : 150 MG) (VITAMIN A : 800 MCG) (VITAMIN E : 40 MG) (SELENIUM : 180 MCG) (COPPER : 0.5 MG) (MANGANESE : 4 MG) (VITAMIN K : 70 MCG)	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) Select Any
0414-140206-1451	(FLUCONAZOLE : 100 MG) CAPSULES (HARD GELATIN)	4	Take 1Tablets 1 Time(s) per Day For 4 Day(s) Select Any

○ 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 : 16-Dec-2023
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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