eASOAP FORM

NEXTCARE Your Health Managed with Care

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

Patent Name:	**Leen Alkhoury**	Gender:	**Female**	Validity Between:	**01/01/1900 and 27/02/2024**
Card No:	**9C67-F83A-B550-298C**	DOB:	**1/30/1999 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1999-9944975-6**	Service Date:	**18-Dec-2023**	Radiology:	**Covered**
		Patent's Tel No:	**522214913**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41905**	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
dry and wet cough			
pain in nasopharynx			
all muscular pain			
FEVER WITH CHILLS			

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 : 108 T : 36.9 HR : 86 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R50.9	Fever, unspecified
Secondary	R52	Pain, unspecified
Secondary	H92.01	Otalgia, right ear
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:		

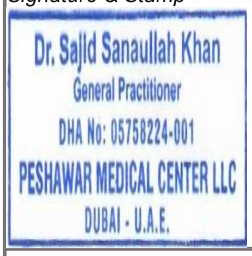
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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
86140	C-reactive Protein	Lab	15.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
0102-111908-1001	SODIUM CHLORIDE B.P.-(SODIUM CHLORIDE : 0.9% W/V) SOLUTION FOR INFUSION	Pharmacy	4.5000
96374	IV PUSH	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000

Code	Generic	Duration	Instructions
5692-273401-1451	(OSELTAMIVIR (AS PHOSPHATE) : 75 MG) CAPSULES (HARD GELATIN)	5	Take 1Tablets 2Time(s) perDay For 5 Day(s) others
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	3	Take 8ML 1 Time(s) per Day For 3 Day(s) others
0005-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) others
0788-106705-1171	(CHLORPHENIRAMINE MALEATE : 2 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	10	Take 1Tablets 3 Time(s) per Day For 10 Day(s) others
0003-388801-2021	(AMINACRINE HCL : 1 MG/ML) (EPHEDRINE HCL : 10 MG/ML) NASAL DROPS	1	Take 2Drops 6 Time(s) per Day For 1 Day(s) others
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	10	Take 1Tablets 3 Time(s) per Day For 10 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	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for*	

medically indicated & necessary for the management of this case.	*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 : 18-Dec-2023
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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