

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MISHRI LAL BAIRWA BHANWARI LAL BAIRWA	Gender:	Male	Validity Between:	01/01/1900 and 31/12/2023
Card No:	81A4-100B-1CF7-97BE	DOB:	8/10/1965 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1965-5720516-6	Service Date:	19-Dec-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	971566695128		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	41925	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):		Date of Symptoms/illness started		
Complaint		DD	MM	YYYY
Red eye since yesterday after going outside something went inside the right eye 18/12/2023				
severe right leg pain and low back pain with sciatica				
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 : 148 T : 36.2 HR : 86 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	T15.90XA	Foreign body on external eye, part unsp, unsp eye, init					
Secondary	H10.521	Angular blepharoconjunctivitis, right eye					
Secondary	M54.5	Low back pain					
Secondary	M54.41	Lumbago with sciatica, right side					

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
9	CONSULTATION GP	General Consultation	25.0000
65210	Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	Co.Pay	50.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000

CPT Code	Treatment	Type	Price
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400

Code	Generic	Duration	Instructions
0085-239201-0371	(DEXAMETHASONE : 0.10%) (TOBRAMYCIN : 0.3%) EYE DROPS	7	Take 1Drops 4 Time(s) per Day For 7 Day(s) others
0152-149901-0291	(DICLOFENAC SODIUM : 1%) EMULGEL	6	Take 1Gel 3 Time(s) per Day For 6 Day(s) others
4417-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED TABLETS	6	Take 1Tablets 4 Time(s) per Day For 6 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Sajid Sanallah		
Tel / Fax (important):		

 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 19-Dec-2023
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

Disclaimer: NEXtCARE ASOAP form is used for claim creation 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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.