

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MUHAMMAD FASIL MADATHIL POCKER	Gender:	Male	Validity Between:	29/01/2023 and 28/01/2024
Card No:	ABE1-E092-FEE1-EA2D	DOB:	1/3/1993 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1993-6543686-6	Service Date:	27-Dec-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0521023311		
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:	39133	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
SEVERE CHEST PAIN SINCE TODAY MORNING WHEN AT WORK IN RESTAURANT 26/12/2023					
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 : 123 T : 36.6 HR : 61 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	R07.9	Chest pain, unspecified			
Secondary	R00.1	Bradycardia, unspecified			
Secondary	E03.9	Hypothyroidism, unspecified			

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
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	Co.Pay	20.0000
82550	Creatine kinase (CK), (CPK); total	Lab	20.0000
84484	Troponin, quantitative	Lab	35.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	Lab	20.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000
0188-135906-2441	PULMICORT	Pharmacy	10.4800

CPT Code	Treatment	Type	Price
0006-124513-2071	VENTOLIN NEBULES	General Consultation	1.2300
9	CONSULTATION GP	General Consultation	25.0000
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000

Code	Generic	Duration	Instructions
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

☐ 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 : 27-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.