eASOAP FORM

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

Patent Name:	**CORAZON VELASCO SEMACIO**	Gender:	**Female**	Validity Between:	**04/04/2023 and 03/04/2024**
Card No:	**3730-0B20-4A63-6CE6**	DOB:	**2/7/1986 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1986-3575439-7**	Service Date:	**27-Dec-2023**	Radiology:	**Covered**
		Patent's Tel No:	**971558715814**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42052**	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
C/o: Generalized body pains and weakness, malaise, tiredness, headache, There is no fever, no respiratory symptoms, no GIT symptom, and no urinary symptoms. Previously been managed for anxiety disorder (unspecified).			

Complaint

History of dyspeptic symptoms.

First degree history of DM

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 : 130 T : 36.9 HR : 80 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K29.00	Acute gastritis without bleeding
Secondary	N39.0	Urinary tract infection, site not specified
Secondary	R53.1	Weakness
Secondary	R53.81	Other malaise

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:		

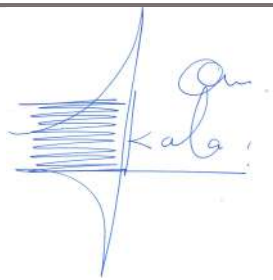
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	CONSULTATION GP	General Consultation	25.0000

CPT Code	Treatment	Type	Price
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
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
86140	C-reactive Protein	Lab	15.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
5676-345301-0391	(MELATONIN : 3 MG) FILM COATED TABLETS	5	Take 2Tablets 1 Time(s) per Day For 5 Day(s) evening
0005-106601-1171	(PARACETAMOL : 500 MG) TABLETS	5	Take 2Tablets 2 Time(s) per Day For 5 Day(s) after meal
0005-141604-0081	(ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS	5	Take 1Tablets 6 Time(s) per Day For 5 Day(s) before meal
0137-242802-0341	(PANTOPRAZOLE (AS SODIUM) : 40 MG) ENTERIC COATED TABLETS	14	Take 1Tablets 2 Time(s) per Day For 14 Day(s) before meal

○ 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 : **Enomen Goodluck**		
Tel / Fax (important):		
Signature & Stamp  	***Patient's Signature(Parent if minor)*** 	
Date :	Date : 27-Dec-2023	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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