

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	CAELAN NILADEVAN DIAZ DE CASTRO	Gender:	Male	Validity Between:	02/10/2023 and 01/10/2024
Card No:	17EE-FC3F-FDB4-AF77	DOB:	1/11/2022 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2022-2723487-3	Service Date:	14-Jan-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0504115175		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	41073	Laboratory:	Covered
Referral No:		Consultation :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
HIGH FEVER AND RESTLESSNESS AND DIARRHEA STARTED TWO DAYS AGO AND HIGH FEVER TODAY 39 DEGREE AND POLYDIPSIA AND POLYURIA STARTED 11/1/2024								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
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 : 39.1		HR : 122		RR	
				: 28							
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	A03.8	Other shigellosis									
Secondary	R50.9	Fever, unspecified									
Secondary	R19.7	Diarrhea, unspecified									
Secondary	E86.0	Dehydration									

ACCIDENT/OCCUPATIONAL Claim Information (complete if claim is a result of accident or work related illness/injury)

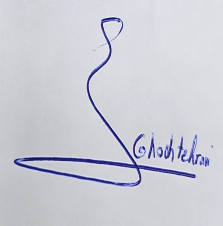
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
82948	Glucose; blood, reagent strip	Lab	10.0000
87045	Culture, bacterial; stool, aerobic, with isolation and preliminary examination (eg, KIA, LIA), Salmonella and Shigella species	Lab	25.0000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
10	Specialist Consultation	General Consultation	45.0000

Code	Generic	Duration	Instructions
1291-605003-0461	(RACECADOTRIL : 10 MG) GRANULES FOR RECONSTITUTION	4	Take 4sachet 1 Time(s) per Day For 4 Day(s) others
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	7	Take 5ML 3 Time(s) per Day For 7 Day(s) others
6616-230505-0832	(SODIUM CHLORIDE : 2.6 G) (POTASSIUM CHLORIDE : 1.5 G) (SODIUM CITRATE : 2.9 G) (DEXTROSE ANHYDROUS : 13.5 G) POWDER FOR SOLUTION	5	Take 1sachet 2 Time(s) per Day For 5 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 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 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.	
Treating Physician Name : Mohammadmahdi		
Tel / Fax (important):		
 Signature & Stamp 	 Patient's Signature(Parent if minor)	
Date :	Date : 14-Jan-2024	
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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