

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	SABAH SHAHID	Gender:	Female	Validity Between:	01/01/1900 and 16/08/2024
Card No:	BFAC-D627-1331-B633	DOB:	9/15/1999 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1999-8130576-8	Service Date:	15-Jan-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0554672683		
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:	41702	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
C/O FEVER ,BODYACHES AND SORE THROAT SINCE YESTERDAY							
ON EXAMINATION PATIENT HAS HYPREMIC THROAT, ENLARGED TONSILS AND MILD CHEST CONGESTION							
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 : 85 T : 36.9 HR : 98 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R50.9	Fever, unspecified					
Secondary	J02.9	Acute pharyngitis, unspecified					
Secondary	R05	Cough					
Secondary	J20.9	Acute bronchitis, 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
9	CONSULTATION GP	General Consultation	25.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
0102-100104-1001	SODIUM CHLORIDE & DEXTROSE B.P.-(SODIUM CHLORIDE : 0.9%) (DEXTROSE : 5%) SOLUTION FOR INFUSION	Pharmacy	4.5000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML-(PARACETAMOL : 10 MG/ML) SOLUTION FOR INFUSION	Pharmacy	8.4000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000

Code	Generic	Duration	Instructions
0205-123701-0392	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0096-106304-0271	(ASCORBIC ACID (VITAMIN C) : 1 G) EFFERVESCENT TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0009-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		
 Signature & Stamp   Patient's Signature(Parent if minor)		
Date :		
Date : 15-Jan-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

Disclaimer: NEXtCARE ASOAP form is used for claim creaton 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

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