eASOAP FORM



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

Patent Name:	SAIDAT NANNOZI	Gender:	Female	Validity Between:	15/04/2023 and 14/04/2024			
Card No:	7F8A-98F3-9A3F-BA38	DOB:	8/5/1999 12:00:00 AM	Coverage Informaton for:	Out Patient			
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF			
Natonal ID:	784-1999-3511267-4	Service Date:	17-Jan-2024	Radiology:	Covered			
		Patent's Tel No:	0561556821					
Policy Holder:		Threshold Limit:						
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal					
		Out-Patent :						
Category:	Category B	Patent's File No:	42250	Pharmacy:	Co-Part: 20%			
Gatekeeper:	No	Consultaton :		Laboratory:	Covered			
Referral No:								
Referred								
Service:								
SUBJECTIVE ASSESSMENT								
Symptom(s) as	Date of Symptoms/illness started							

Past Medical Surgical History? Obs/Gyn Claims Date of Symptoms/illness st 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:99 T:36.5 HR:86 : 22 Assessment/Diagnosis: Acute Chronic Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)	Symptom(s)	as described by th	e patent (Chief	Complain	t):			Date o	f Symptom:	s/illness started
PATIENT ECG AND BASELINE HAS DONE 2 DAYS BACK AND THE RESULT IS NORMAL Past Medical Surgical History? Yes	Complaint						DD	MM	YYYY	
Past Medical Surgical History? Obs/Gyn Claims Date of Symptoms/illness st 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:99 T:36.5 HR:86 : 22 Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/illness occur: Accident or illness due to work? Obscribe how the accident or work related injury/illness occur: Ores No Date of accident or beginning of illness:	,		·			,				
Date of Symptoms/illness st Date of Symptoms/illness st Date of Symptoms/illness st DD MM PYYY Para Gravida: AB: LMP: Marital Status: Marital Date: What date did the Patient first feel same / similar Symptom(s): dd mm yyyy s the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when: DBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:99 T:36.5 HR:86 : 22 Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/illness occur: Injury due to road accident? Describe how the accident or work related injury/illness occur: Yes No Yes No Yes No Opace of accident or beginning of illness: Date of accident or beginning of i	Past Modica	Surgical History2			Vos		O No.	Date of Symptoms/illness starte		
DD MM YYYY	ast ivieuita	- Jurgical History:					ONO	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 s the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when: DBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:99 T:36.5 HR:86 : 22 Assessment/Diagnosis: Acute Chronic INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related injury/illness occur: accident? Oyes No Other of accident or beginning of illness:								Date o	of Symptom	s/illness starte
What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy s the Patient under any type of Treatment?	Jbs/Gyn Cla	ıms						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)	☐ Para	☐ Gravida:	□ АВ:	LMP:	Marital Stati	us:	Marital Date:			
So the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician)										
ASSESSMENT (To be completed by Physician) Vital Signs: B/P:99 T:36.5 HR:86 : 22 Assessment/Diagnosis: Acute Chronic Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system 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? O Yes No Oate of accident or beginning of illness:	Vhat date did	d the Patient first fee	l same / similar :	Symptom(s	s) : dd mm yyy	<u>'Y</u>				
Clinical Findings: Vital Signs: B/P:99 T:36.5 HR:86 : 22 Assessment/Diagnosis:	s the Patient	under any type of Ti	reatment? O Y	es 🔾 No	if yes, indica	ite what Asse	essment and since	when:		
Clinical Findings: Vital Signs: B/P:99 T:36.5 HR:86 : 22 Assessment/Diagnosis:	D IECTIVE	/ ASSESSMENT/To	he completed by	, Physician	,					
Assessment/Diagnosis: Acute Chronic Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system 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? O Yes O No Date of accident or beginning of illness:		· · ·	be completed by	Priysician)	h.r. 10:	D/D 00	T 26.5		0.0
Type Code Diagnosis Primary R29.91 Unsp symptoms and signs involving the musculoskeletal system 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 Date of accident or beginning of illness:	Jillicai Filiu	iliys .					В/Р : 99	1:36.5	нк:	86
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ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury) Accident or illness due to work? Orea No Orate of accident or beginning of illness: Describe how the accident or work related injury/illness occur: Orea No Orate of accident or beginning of illness:	Туре	Code	Diagnosis							
Accident or illness due to work? Injury due to road accident? Describe how the accident or work related injury/illness occur: Yes	Primary	R29.91	Unsp symp	toms and s	signs involving	g the musculo	oskeletal system			
Accident or liness due to work? O Yes O No Date of accident or beginning of illness:	ACCIDENT/C	OCCUPATIONAL Cla	im Informaton	(complete	e if claim is a ı	esult of acci	dent or work relate	ed illness/inju	ıry)	
Date of accident or beginning of illness:	INCCIDENT OF IIINESS ONE TO WORKS				Describe how the accident or work related injury/illness occur:					
• •	○Yes ○N	lo		○ Yes ○	O No					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim	Date of accid	dent or beginning o	f illness:							
	MEDICAL PL	AN Itemized Origin	al Invoices and	Applicable	Prescriptions	s / Reports /	Results must be en	closed to con	sider claim	

CPT Code Treatme		ent	Гуре			Price	
9 CONSUL		JLTATION GP		General Consultation			25.0000
Code	Generic			Duration	Instructions		
0717-226501-2401	(EPERISONE	EPERISONE : 50 MG) SUGAR COATED TABLETS			Take 1Tablets 1 Time(s) per Day For 10 Day(s) others		
0005-101701-0391	(ACECLOFE	NAC : 100 MG) FILM COATED TABLET	S	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)		
O Pharmacy:		Estmated Costs	0) Laboratory	/ Radiology:	Estmated Costs	
		O Surgery:	0	Endoscopy:			
Is the following required		O Physiotherapy:	0	Other Proc	edures:		
			If yes please specify				

Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Er	
& that the medical services shown on this form were	release any informaton regarding my medical condito	
medically indicated & necessary for the management of	the purpose of determining insurance benefts. Medica	al management is the sole
this case.	responsibility of doctor and the patent.	
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		
Signature & Stamp Dr. Sajid Sanauliah Khan General Practitioner DHA NO: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAI • U.A.E. Date:	Patient's Signature(Parent if minor) Date: 17-Jan-2024	
	1 11 1	
Note: Claims must be submited along with supporting doc	cuments within 30 days from date of service	

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