

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	AYAAN ABDULLAH SUMAN	Gender:	Male	Validity Between:	22/02/2023 and 21/02/2024
Card No:	7217-CD6D-B366-25A4	DOB:	2/10/2019 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (AI Ansari-AUH)-MEDGULF
Natonal ID:	784-2019-2168314-6	Service Date:	25-Jan-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0504290935		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	40720	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
severe vomiting								
High fever and abdominal pain since two days ago on 23/1/2024								
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 : 37.9 HR : 115 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J02.9	Acute pharyngitis, unspecified					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	R11.2	Nausea with vomiting, unspecified					

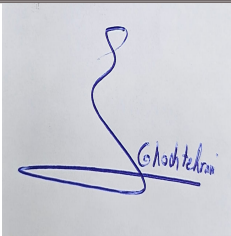
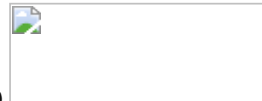
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

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
10	Specialist Consultation	Specialist Consultation	45.0000
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	Co.Pay	15.0000
0006-124513-2071	VENTOLIN NEBULES	Pharmacy	1.2300
0188-135906-2441	PULMICORT	Pharmacy	10.4800
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
0005-150403-1021	PREMOSAN	Pharmacy	0.9000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000

Code	Generic	Duration	Instructions
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	7	Take 3ML 2 Time(s) per Day For 7 Day(s) others
0031-168202-1111	(DOMPERIDONE : 1 MG/ML) SUSPENSION	5	Take 4ML 2 Time(s) per Day For 5 Day(s) others
0207-142903-0851	(CEFEXIME : 100 MG/5ML) POWDER FOR SUSPENSION	5	Take 5ML 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 benefets. Medical management is the sole responsibility of doctor and the patent.		
Treating Physician Name : Mohammadmahdi		
Tel / Fax (important):		
<i>Signature & Stamp</i>  Dr. Mohammadmahdi Ghodstehrani Specialist Neonatology DHA No: 00045407-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E. <i>Patient's Signature(Parent if minor)</i> 		
Date : 25-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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