eASOAP FORM

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

Patent Name:	**EHAB MAHMOUD HAMOUDA**	Gender:	**Male**	Validity Between:	**05/03/2023 and 04/03/2024**
Card No:	**E06B-88CC-4DAF-173A**	DOB:	**10/16/1964 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1964-7617374-3**	Service Date:	**28-Jan-2024**	Radiology:	**Covered**
		Patent's Tel No:	**971507343592**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39887**	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: Chest pain, elevated blood pressure on the left arm (175/100mmhg) and normal on the right arm (130/70mmhg). Coaraction of the aorta suspected. Refer to cardiologist			

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 : 128 T : 36.3 HR : 76 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I15.8	Other secondary hypertension
Secondary	J01.00	Acute maxillary sinusitis, unspecified
Secondary	R51.9	Headache, unspecified
Secondary	J01.10	Acute frontal sinusitis, unspecified
Secondary	R53.1	Weakness

Type	Code	Diagnosis
Secondary	R07.9	Chest pain, 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:		

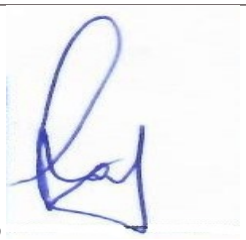
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)	Lab	30.0000
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000
86140	C-reactive Protein	Lab	15.0000
82310	Calcium; total	Lab	10.0000
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
6445-379202-1171	(AMLODIPINE (AS BESYLATE) : 10 MG) TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) morning
0788-107203-1171	(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0027-149903-0111	(DICLOFENAC SODIUM : 100 MG) COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal
0030-183202-0391	(FEXOFENADINE HCL : 180 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0027-128802-2021	(XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS	7	Take 2Drops 2 Time(s) per Day For 7 Day(s) others

○ 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 : **Sajid Sanaullah**		
Tel / Fax (important):		

Signature & Stamp  	***Patient's Signature(Parent if minor)*** 
Date :	Date : 28-Jan-2024
Note: Claims must be submited along with supportng 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 efects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.