eASOAP FORM



ADMINISTRATIVE The member is allowed for **Out Patient** at the Irham Medical Center Arjan **ANKIT UPADHYAY** 29/11/2023 and 28/11/2024 Patent Name: Gender: Male Validity Between: **Coverage Information** 9/28/1988 12:00:00 Card No: 6142-A06E-3E5C-68DF DOB: **Out Patient** RN UAE (Al Ansari-AUH)-Pin #: **Identty Card:** Network: **MEDGULF** Natonal ID: 784-1988-1354638-3 Service Date: 01-Feb-2024 Radiology: Covered Patent's Tel No: 586868076 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Class: Normal Payer Name: P.J.S.C Out-Patent: Patent's File 42393 Co-Part: 20% Category: **Category B** Pharmacy: No: Consultation: Laboratory: Gatekeeper: Covered Referral No: Referred Service: SUBJECTIVE ASSESSMENT Date of Symptoms/illness started Symptom(s) as described by the patent (Chief Complaint): DD MM YYYY Complaint SEVERE STOMACH PAIN SINCE YESTERDAY 31/1/2024 SEVERE FLATUS AND VOMITING Date of Symptoms/illness started ○Yes O No Past Medical Surgical History? MM YYYY Date of Symptoms/illness started Obs/Gyn Claims DD YYYY MM ☐ Para ☐ Gravida: ☐ AB: LMP: Marital Date: Marital Status: What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy Is the Patient under any type of Treatment? \bigcirc Yes \bigcirc No $\stackrel{.}{}$ if yes, indicate what Assessment and since when: OBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs: B/P:110 T:36.8 HR: 82 RR : 22 O Chronic O Acute Assessment/Diagnosis : O Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code **Diagnosis**

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

Gastro-esophageal reflux disease without esophagitis

Acute gastritis without bleeding

Abdominal distension (gaseous)

Nausea with vomiting, unspecified

Flatulence

K29.00

R14.3

R14.0

R11.2

K21.9

Primary

Secondary Secondary

Secondary

Secondary

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d Original Inv	voices and Applicable	Prescriptions /	Reports /	Results mus	t be enclosed	to consider claim	
Treatment					Туре	Price	
Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)					e Co.Pay	3.0000	
Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour						Co.Pay	40.0000
PREMOSAN					Pharmacy	0.9000	
PANTONIX 40MG I.V.					Pharmacy	29.5000	
SODIUM CHLORIDE & DEXTROSE B.P.					Pharmacy	4.5000	
CONSTITATION GP					General Consultation	25.0000	
Generic				Duration	Instructions		
(DIMETHICONE : 20 MG) TABLETS				8	Take 2Tablets 3 Time(s) per Day For 8 Day(s) others		
(DOMPERIDONE : 10 MG) FILM COATED TABLETS				15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others		
(PANTOPRAZOLE (AS SODIUM) : 40 MG) DELA TABLET			RELEASE	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) others		
	Estmated Costs		O Laboratory / Radiology:		Estmated Costs		
Surgery: O Surgery: Physiotherapy:			O Endoscopy:				
			If yes please specify				
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I hereby certfy that all informaton mentoned are correct	I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to			
& that the medical services shown on this form were	release any informaton regarding my medical conditon and history to NEXtCARE for			
medically indicated & necessary for the management of	the purpose of determining insurance benefts. Medical management is the sole			
this case.	responsibility of doctor and the patent.			
Treating Physician Name : Sajid Sanaullah				
Tel / Fax (important):				
Signature & Stamp Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E. Date:	Patient's Signature(Parent if minor) Date: 01-Feb-2024			
	,			
Note: Claims must be submited along with supporting documents within 30 days from date of service				

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