

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	Muhammad Ryyan Ali	Gender:	Male	Validity Between:	15/06/2023 and 14/06/2024
Card No:	9E94-61EC-FF26-0CB3	DOB:	6/16/2023 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-2023-9262687-9	Service Date:	04-Feb-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0559700666		
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:	41500	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: High grade fever, vomiting and diarrhea.								
Temperature at home was 39 degrees.								
Exam:								
No significant finding, except for mild pharyngeal hyperemia.								
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 : 106	RR
				: 32			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J00	Acute nasopharyngitis [common cold]					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	R50.9	Fever, 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
Code	Generic	Duration	Instructions
0788-106604-1111	(PARACETAMOL : 120 MG/5ML) SUSPENSION	5	Take 5ML 3 Time(s) per Day For 5 Day(s) others
0097-230603-2091	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER	3	Take 1Solution 1Time(s) perDay For 3 Day(s) others
0027-149905-2231	(DICLOFENAC SODIUM : 12.5 MG) RECTAL SUPPOSITORIES	5	Take 1Suppository 1 Time(s) per Day For 5 Day(s) after meal
1086-123702-1381	(CETIRIZINE HCL : 1 MG/ML) SOLUTION (ORAL)	10	Take 3ML 1 Time(s) per Day For 10 Day(s) after meal
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	5	Take 5ML 2 Time(s) per Day For 5 Day(s) after meal
0325-142903-0851	(CEFIXIME : 100 MG/5ML) POWDER FOR SUSPENSION	7	Take 5ML 1Time(s) perDay For 7 Day(s) after meal
☐ 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 benefsts. 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 : 04-Feb-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 responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.