



eASOAP FORM

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

Patent Name:	RAFIQUE MIZANUR RAHMAN	Gender:	Male	Validity Between:	14/06/2023 and 31/05/2024
Card No:	555D-A59B-EC73-5C89	DOB:	3/1/1986 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1986-8292044-6	Service Date:	13-Feb-2024	Radiology:	Covered
		Patent's Tel No:	557784042		
Policy Holder:		Threshold Limit:			
Payer Name:	UNION INSURANCE COMPANY	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42481	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 DRY COUGH ,FEVER ,BODY PAIN SINCE 5 DAYS								
O/E PT HAS HYPREMIC THROAT AND MILDLY INFLAMMED TONSILS								
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 : 155 T : 36.8 HR : 88		
			RR : 22		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	J03.90	Acute tonsillitis, unspecified			
Secondary	R50.9	Fever, unspecified			
Secondary	R05	Cough			

Type	Code	Diagnosis
Secondary	R52	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
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
85651	Sedimentation rate, erythrocyte; non-automated	Lab	10.0000
9	CONSULTATION GP	General Consultation	25.0000
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
86140	C-reactive Protein	Lab	15.0000

Code	Generic	Duration	Instructions
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0006-106601-0392	(PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 2Tablets 3 Time(s) per Day For 5 Day(s) others
1144-253101-1162	(HEDERA HELIX (IVY) : 7MG/ML) SYRUP	7	Take 10ML SYRUP 1 Time(s) per Day For 7 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs
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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 benefsts. Medical management is the sole responsibility of doctor and the patent.		

Treating Physician Name : Sajid Sanaullah	
Tel / Fax (important):	
 <i>Signature & Stamp</i> 	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 13-Feb-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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