eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**CAROLINA JAPA**	Gender:	**Female**	Validity Between:	**01/09/2023 and 31/08/2024**
Card No:	**E64D-F765-50C5-58E5**	DOB:	**12/12/1971 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1971-8624032-7**	Service Date:	**17-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0502209194**		
Policy Holder:		Threshold Limit:			
Payer Name:	**RAS AL KHAIMAH NATIONAL INSURANCE COMPANY (RAK)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42526**	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
RBS = 136mg/dl (normal). Counselled to reduced insulin dose from 25IU to 18IU C/o: Requesting medication refill. Known hypertensive and diabetic. Patient is well and has no complaint. Claims good compliance to medications. RBS, CBC, HBA1c and lipid profile			

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 : 107 T : 36.6 HR : 81 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I10	Essential (primary) hypertension
Secondary	E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
Secondary	E78.2	Mixed hyperlipidemia
Secondary	I20.9	Angina pectoris, unspecified
Secondary	M79.2	Neuralgia and neuritis, 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
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
83036	Hemoglobin; glycosylated (A1C)	Lab	30.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000

Code	Generic	Duration	Instructions
0321-100604-1171	(VITAMIN B12 : 200 MCG) (THIAMINE (VITAMIN B1) : 100 MG) (PYRIDOXINE (VITAMIN B6) : 200 MG) TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0030-244101-0391	(CLOPIDOGREL : 75 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) after meal
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0027-179203-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) morning
0090-204901-0391	(SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 1000 MG) FILM COATED TABLETS	60	Take 1Tablets 2 Time(s) per Day For 60 Day(s) after meal
0170-208601-1021	(INSULIN - GLARGINE : 100 IU/ML) SOLUTION FOR INJECTION	60	Take 18Units 3 Time(s) per Day For 60 Day(s) after meal

○ 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 Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 17-Feb-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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