eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**HAZEL DIANE BASIG**	Gender:	**Female**	Validity Between:	**23/11/2023 and 23/02/2024**
Card No:	**72DE-D44E-1B83-6241**	DOB:	**1/16/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-4709050-7**	Service Date:	**18-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0507359179**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42530**	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 FEVER,VOMITING ,LOOSE STOOL SINCE 2 DAYS VOMITING AND NAUSEA SINCE MORNING NO KNOWN MEDICINE ALLERGIES			

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 : 105 T : 36.7 HR : 72 RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R19.7	Diarrhea, unspecified
Secondary	A09	Infectious gastroenteritis and colitis, unspecified
Secondary	R11.2	Nausea with vomiting, unspecified
Secondary	R50.9	Fever, unspecified

Type	Code	Diagnosis
Secondary	E86.0	Dehydration

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
82248	Bilirubin; direct	Lab	10.0000
82247	Bilirubin; total	Lab	10.0000
84075	Phosphatase, alkaline;	Lab	10.0000
84450	Transferase; aspartate amino (AST) (SGOT)	Lab	15.0000
84460	Transferase; alanine amino (ALT) (SGPT)	Lab	10.0000
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
82948	Glucose; blood, reagent strip	Lab	10.0000
86140	C-reactive Protein	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-242802-0781	PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION	Pharmacy	29.5000
0005-136504-1021	SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION	Pharmacy	4.6000
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Co.Pay	25.0000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
0097-397801-0391	(DOMPERIDONE (AS MALEATE) : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) others
0102-230603-0831	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) before meal
1308-232401-1452	(ESOMEPRAZOLE : 40 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) before meal
0152-116602-0391	(METRONIDAZOLE : 250 MG) FILM COATED TABLETS	5	Take 1Tablets 3 Time(s) per Day For 5 Day(s) after meal
5098-482002-0391	(CIPROFLOXACIN (AS HYDROCHLORIDE) : 250 MG) FILM COATED TABLETS	5	Take 2Tablets 2 Time(s) per Day For 5 Day(s) after meal

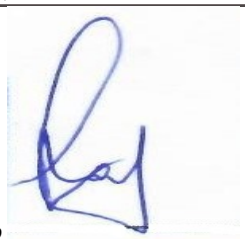
○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated Costs

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

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

this case.	*responsibility of doctor and the patent.*
Treating Physician Name : **Sajid Sanaullah**	
Tel / Fax (important):	
 *Signature & Stamp* 	 ***Patient's Signature(Parent if minor)***
Date :	Date : 18-Feb-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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