eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**EDWARD ABDALLAH NAEEM MAAYAH**	Gender:	**Male**	Validity Between:	**23/05/2023 and 22/05/2024**
Card No:	**99C9-F215-5061-7874**	DOB:	**7/20/2022 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-2022-5209364-0**	Service Date:	**19-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**971508999740**		
Policy Holder:		Threshold Limit:			
Payer Name:	**AL SAGAR NATIONAL INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39593**	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**		
	DD	MM	YYYY
Complaint High fever and severe cough since three days started 16/2/2024 severe eye discharge since yesterday			

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 : 0 T : 39 HR : 122 RR : 26

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

Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	H66.015	Acute suppr otitis media w spon rupt ear drum, recur, l ear
Secondary	J20.9	Acute bronchitis, unspecified
Secondary	J04.0	Acute laryngitis

Type	Code	Diagnosis
Secondary	R06.1	Stridor

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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0006-402803-2071	VENTOLIN NEBULES	Pharmacy	1.5300
0188-135906-2441	PULMICORT	Pharmacy	10.4800
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	Co.Pay	20.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy	1.2000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy	2.3400
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000

Code	Generic	Duration	Instructions
0207-142903-0851	(CEFIXIME : 100 MG/5ML) POWDER FOR SUSPENSION	5	Take 3ML 2 Time(s) per Day For 5 Day(s) others
0031-103204-0371	(CIPROFLOXACIN : 0.3%) EYE DROPS	5	Take 1Drops 4 Time(s) per Day For 5 Day(s) others
0252-149905-2231	(DICLOFENAC SODIUM : 12.5 MG) RECTAL SUPPOSITORIES	5	Take 1Suppository 2 Time(s) per Day For 5 Day(s) others

○ 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 	***Patient's Signature(Parent if minor)***

	
Date :	Date : 19-Feb-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	