



eASOAP FORM

ADMINISTRATIVEThe 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		
Complaint						DD	MM	YYYY
High fever and severe cough since three days started 16/2/2024								
severe eye discharge since yesterday								
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 : 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:		

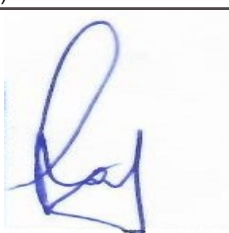
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

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:	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>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 benefets. 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 : 19-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 creation 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 final opinion will be given by the NEXtCARE claims doctors.