eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**SHAHAB UD DIN MUHAMMAD SADIQ**	Gender:	**Male**	Validity Between:	**08/09/2023 and 07/09/2024**
Card No:	**DEA4-1462-B77C-3080**	DOB:	**3/30/1985 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1985-2709418-3**	Service Date:	**20-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0521194600**		
Policy Holder:		Threshold Limit:			
Payer Name:	**UNITED INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**38581**	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 PAIN IN LEFT ILIAC FOSSA SINCE 2 DAYS , THERE IS NO KNOWN RELIEVING OR AGGRAVATING FACTORS OF PAIN					
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 : 93 T : 36.6 HR : 87 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R25.2	Cramp and spasm
Secondary	R52	Pain, unspecified
Secondary	R10.32	Left lower quadrant pain
Secondary	N39.0	Urinary tract infection, site not specified
Secondary	K59.00	Constipation, 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
80069	Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)	Lab	120.0000
85651	Sedimentation rate, erythrocyte; non-automated	Lab	10.0000
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy	Lab	8.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
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
0005-136504-1021	SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION	Pharmacy	4.6000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000

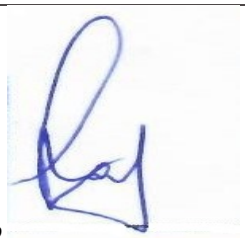
Code	Generic	Duration	Instructions
0042-136501-1171	(HYOSCINE : 10 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
1291-170801-1161	(LACTULOSE : 66.7%) SYRUP	7	Take 1OML SYRUp 1 Time(s) per Day For 7 Day(s) others
0086-225101-2091	(POTASSIUM CHLORIDE : 46.6 MG) (POLYETHYLENE GLYCOL : 13.125 G) (SODIUM BICARBONATE : 178.5 MG) (SODIUM CHLORIDE : 350.7 MG) ORAL POWDER	5	Take 1sachet 2 Time(s) per Day For 5 Day(s) others
6616-998901-0251	(SODIUM BICARBONATE BP : 1.77G) (SODIUM CITRATE (ANHYDROUS) USP : 0.61G) (CITRIC ACID (ANHYDROUS) BP : 0.59 G) (TARTARIC ACID BP : 0.89G) (CRANBERRY EXTRACT HIS : 0.1 G) EFFERVESCENT GRANULES	5	Take 1sachet 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 : 20-Feb-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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