eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**Mohammed Shahid Shahid**	Gender:	**Male**	Validity Between:	**01/12/2023 and 30/11/2024**
Card No:	**18C5-17C1-88B9-0EA7**	DOB:	**3/23/1987 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1987-9613574-1**	Service Date:	**21-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**523024441**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Islamic Arab Insurance Co. (P.S.C.**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42568**	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: Recurrent dry cough, no fever, Known hypertensive and diabnetic					
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 : 149 T : 36.7 HR : 80 RR : 20

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	I10	Essential (primary) hypertension
Secondary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unsp
Secondary	M54.5	Low back pain

Type	Code	Diagnosis
Secondary	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed

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

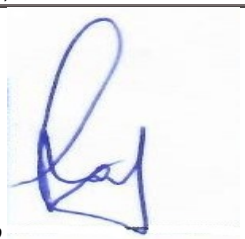
CPT Code	Treatment	Type	Price
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
0090-122303-0392	(ETORICOXIB : 90 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) after meal
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) before meal
0027-179202-0391	(AMLODIPINE : 10 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) morning
0011-528301-0391	(DAPAGLIFLOZIN (AS PROPANEDIOL) : 10 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0090-205003-0391	(SITAGLIPTIN (AS PHOSPHATE) : 100 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) after meal
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	30	Take 1Units 2 Time(s) per Day For 30 Day(s) evening

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

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