ADMINISTRATIVE

Type

Primary

Secondary

Secondary

Code

R50.9 M79.10

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eASOAP FORM



at the Irham Medical Center Arjan

MUHAMMED AL BAZAM Patent Name: Gender: Male Validity Between: 15/05/2023 and 14/05/2024 THAYYIL MOHAMMED Coverage Information 10/26/1994 12:00:00 DB48-AAD3-8399-46E3 **Out Patient** Card No: DOB: AM RN UAE (Al Ansari-AUH)-Pin #: **Identty Card:** Network: **MEDGULF** Natonal ID: 784-1994-7654842-7 Service Date: 21-Feb-2024 Radiology: Covered Patent's Tel No: 589167610 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Class: Normal Payer Name: P.J.S.C Out-Patent: Patent's File 42570 Co-Part: 20% **Category B** Pharmacy: Category: No: Gatekeeper: No Consultation: Laboratory: Covered Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started bb MM YYYY Complaint Body pains and cough since 3days. Cough is productive of yellow sputum Date of Symptoms/illness started Past Medical Surgical History? O Yes O No DD ММ YYYY Date of Symptoms/illness started Obs/Gyn Claims bb YYYY MM Para Gravida: AB: LMP: Marital Status: Marital Date: What date did the Patient first feel same / similar Symptom(s): dd mm yyyy ls the Patient under any type of Treatment? O Yes O 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: 82 RR: 22 Assessment/Diagnosis: O Acute O Chronic O Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM

The member is allowed for Out Patient

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Unspecified acute lower respiratory infection

Fever, unspecified

Myalgia, unspecified site

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Treating Physician Name : Sajid Sanaullah Tel / Fax (important):	ACCIDENT/OCCUPATION	ONAL Claim Informaton	(complete i	if claim is	a result of accident or v	work related ill	ness/injury)			
Date of accident or beginning of illness: MEDICAL PLAN Hemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Hemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Hemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Type Price 9 CONSULTATION GP General Consultation 25,0000 Code Generic Duration Instructions 1516-107902-1171 (IBUPROFEN: 400 MG) TABLETS 5 Take 17ablets 2 Time(s) per Day For 5 Day(s) after meal 1204-571401-1161 (GUAIFENESIN: 100 MG/5ML) [PSEUDOEPHEDRINE HCL: 30 7 Day(s) after meal 1204-571401-1161 (IPUPROLIDINE HCL: 1.25 MG/5ML) SYRUP 7 Day(s) after meal 0252-185801-0391 (PERMOLIDINE: 25 MG) [PARACETAMOL: 500 MG) (PSEUDOEPHEDRINE: 30 MG) FLIM COATED TABLETS 10 Take 17ablets 2 Time(s) per Day For 10 Day(s) after meal 0139-116206-1171 (CLAVULANIC ACID: 125 MG) (AMOXICILLIN: 875 MG) TABLETS 7 Take 17ablets 2 Time(s) per Day For 7 Day(s) after meal OPharmacy: Estmated Costs	Accident or illness due	to work?		to road	Describe how the a	Describe how the accident or work related injury/illness occur:				
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Is In-patient Required? Length of Stay Is In-patient Required? Length of Stay Indicate Provider I hereby certfy that all informaton mentoned are correct at the medical services shown on this form were medically indicated & necessary for the management of 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 Dr. Sajid Sanaullah Khan Genral Practitioner DIA IN: \$155824-011 PESHAWA MEDICAL CENTER LC DIBNIJALE. Patient's Signature(Parent if minor) Date: Date: 21-Feb-2024		•	O Su	rgery:	O Endoscopy:					
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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 Dr. Sajid Sanaullah Khan General Practitioner OHA No: 05750224-001 PESHAWAR MEDICAL CENTER LLC UUBAI-U.A.E. Patient's Signature(Parent if minor) Date: 21-Feb-2024										
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Disclaimer: NEXtCARE ASOAP form is used for claim creaton 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 efects 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.

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