eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**GIRIJA BHARGAVI CHAKRAPANI**	Gender:	**Male**	Validity Between:	**07/01/2024 and 06/01/2025**
Card No:	**B0EF-339B-C1B7-51E9**	DOB:	**12/22/1966 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1966-7576151-2**	Service Date:	**22-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0558152507**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42515**	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 c/o: Generalized body pains, especially low back pain, Also has pain in throat, cough that is productive of clear sputum. Also complaining of right sided flank pain with left side lower abdominal pain. Exam: abdomen is full with marked tenderness at the left iliac fossa, and positive renal angle tenderness of the right.			

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 : 148 T : 36.8 HR : 84 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J02.8	Acute pharyngitis due to other specified organisms
Secondary	N10	Acute pyelonephritis
Secondary	N20.2	Calculus of kidney with calculus of ureter

Type	Code	Diagnosis
Secondary	N83.292	Other ovarian cyst, left side
Secondary	K57.92	Dvtrcli of intest, part unsp, w/o perf or abscess w/o bleed
Secondary	I10	Essential (primary) hypertension
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed
Secondary	M54.5	Low back pain

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

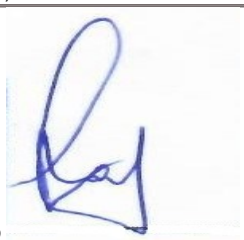
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
9.01	Follow-up consultation	General Consultation	0.0000
84550	Uric acid; blood	Lab	15.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	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
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Radiology	100.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
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

Code	Generic	Duration	Instructions
4874-125821-3801	(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	7	Take 1Spray 4 Time(s) per Day For 7 Day(s) others
1204-571401-1161	(GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	5	Take 1sachet 3 Time(s) per Day For 5 Day(s) after meal
0188-232402-0391	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) before meal
0053-111703-0251	(SODIUM CITRATE : 630 MG) (TARTARIC ACID : 890 MG) (SODIUM BICARBONATE : 1.75 G) (CITRIC ACID : 720 MG) EFFERVESCENT GRANULES	7	Take 1sachet 3Time(s) perDay For 7 Day(s) others
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal

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

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