ADMINISTRATIVE

Primary

Secondary

Secondary

Secondary

J22

J45.20

J02.9

110

eASOAP FORM



at the Irham Medical Center Arjan

JONEL RAY FUNDEMERA Gender: Male Validity Between: 09/01/2024 and 31/08/2024 Patent Name: 12/24/1990 12:00:00 Coverage Information Card No: 84C7-6C2E-54C9-F447 DOB: **Out Patient** AM for: RN UAE (Al Ansari-AUH)-Pin #: Identty Card: Network: **MEDGULF** Natonal ID: 784-1990-8831492-9 Service Date: 22-Feb-2024 Covered Radiology: Patent's Tel No: 0567379246 Threshold Policy Holder: Limit: **ORIENT INSURANCE** Payer Name: Class: Normal P.J.S.C Out-Patent: Patent's File 42583 Category: Category B Pharmacy: Co-Part: 20% No: Consultation: Laboratory: Covered Gatekeeper: No Referral No: Referred Service: SUBJECTIVE ASSESSMENT Symptom(s) as described by the patent (Chief Complaint): Date of Symptoms/illness started bb MM YYYY Complaint C/o: Fever since 5 days, cough and generalized body pains. Also has upper abdominal pain Past medical history significant for hypertension. Date of Symptoms/illness started Past Medical Surgical History? O Yes O No DD MM YYYY Date of Symptoms/illness started Obs/Gyn Claims ММ YYYY 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:135 T:36.7 HR: 90 RR: 22 O Chronic Assessment/Diagnosis: Acute Confirmed Suspected INDICATE DIAGNOSIS NOT SYMPTOM Type Code **Diagnosis**

The member is allowed for Out Patient

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Unspecified acute lower respiratory infection

Mild intermittent asthma, uncomplicated

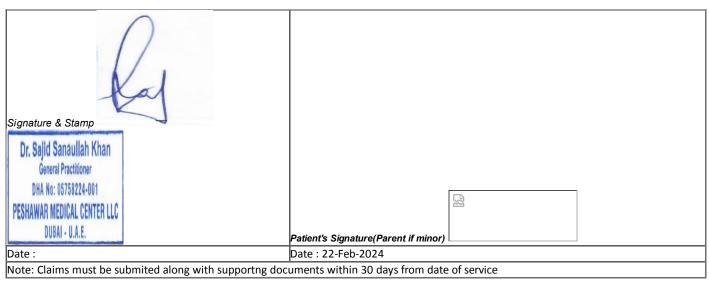
Acute pharyngitis, unspecified

Essential (primary) hypertension

Туре	Code	Diagnosis	
Secondary	J30.9	Allergic rhinitis, unspecified	
Secondary	K29.00	Acute gastritis without bleeding	
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)			

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/inj Injury due	
Accident or illness due to work? To road accident? Yes No Date of accident or beginning of illness: MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to con	ury)
Date of accident or beginning of illness: MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to cor	d injury/illness occur:
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to cor	
CPT Code Treatment Type	nsider claim
1,160	Price
9 CONSULTATION GP General Consultation	25.0000
Code Generic Duration Instruct	tions
	ablets 1 Time(s) per Day For (s) after meal
	ablets 2 Time(s) per Day For (s) after meal
110106-11166111-11393 12080(E10M(I)) · 51111M(I) E11M(I) (101E1) 1081E1X	ablets 3 Time(s) per Day For) after meal
	ablets 2 Time(s) per Day For) after meal
	ablets 1 Time(s) per Day For (s) evening
	ablets 2Time(s) perDay For (s) before meal
	ablets 1 Time(s) per Day For (s) morning
	ablets 1 Time(s) per Day For (s) evening
0188-135906-2441 (BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION 30 Take 1L Day(s) 6	Jnits 1Time(s) perDay For 30 evening
O Pharmacy: Estmated Costs O Laboratory / Radiology: Estma	ited Costs
Surgery: Endoscopy:	
Is the following required Physiotherapy: Other Procedures:	
If yes please specify	
ls In-patient Required ? Length of Stay Indicate Provider	Estimate Cost
I hereby certfy that all informaton mentoned are correct & the the medical services shown on this form were medically indicated & necessary for the management of this case. I hereby authorize any Healthcare Provider, Insurer, Employee and the provider of the release any information regarding my medical conditions for the purpose of determining insurance benefits. Medically indicated & necessary for the management of the purpose of determining insurance benefits. Medically indicated & necessary for the management of the purpose of determining insurance benefits.	on and history to NEXtCARE
Treating Physician Name : Sajid Sanaullah Tel / Fax (important):	

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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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