

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MUHAMMAD ARSHAD SONI	Gender:	Male	Validity Between:	03/03/2023 and 02/03/2024
Card No:	4F59-0834-3404-881C	DOB:	1/1/1977 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1977-6539653-2	Service Date:	24-Feb-2024	Radiology:	Covered
		Patent's Tel No:	0502245886		
Policy Holder:		Threshold Limit:			
Payer Name:	Islamic Arab Insurance Co. (P.S.C.)	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	36406	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: Wound on the anus, associated with purulent discharge. Had fistulectomy 10days prior to presentation at International Modern Hospital, Dubai. His antibiotics now finished. He is not a known diabetic and has no other medical condition. Investigation report seen shows adequate PCV. Exam: A circumscribed dirty wound on the left wall of the anal cleft, measures 5cm in diameter, has slough over it's surface with active purulent exudates, it is tender and has a firm base. Another linear similarly dirty wound on the right wall of the anal cleft. Daily wound dressing is advised.								
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 : 128	T : 36.7	HR : 94	RR : 22
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Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
 INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K60.3	Anal fistula
Secondary	K61.39	Other ischiorectal abscess

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
12021	Treatment of superficial wound dehiscence; with packing	Co.Pay	45.0000
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	Co.Pay	15.0000
9	CONSULTATION GP	General Consultation	25.0000

Code	Generic	Duration	Instructions
0005-106601-1171	(PARACETAMOL : 500 MG) TABLETS	5	Take 2Tablets 3 Time(s) per Day For 5 Day(s) after meal
0152-116604-0391	(METRONIDAZOLE : 500 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
1161-274301-0392	(LEVOFLOXACIN (AS HEMIHYDRATE) : 500 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening

☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>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>		
<i>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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>		
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		
 Signature & Stamp 		
Date : Patient's Signature(Parent if minor)		
Date : 24-Feb-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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 effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEXtCARE claims doctors.