eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**SHIRANI FERNANDO MADURAPPULIGE**	Gender:	**Female**	Validity Between:	**04/10/2023 and 03/10/2024**
Card No:	**8DEB-B890-8B98-DEA7**	DOB:	**9/24/1966 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1966-6328915-3**	Service Date:	**25-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**524010645**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42608**	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: Pain in the right shoulder, since the past one month. Said to have began about 3weeks after a fall from chair upon which she was standing. Pain now radiates to the the distal part of the right limb. Pain is aggravated by movement of the affected shoulder. Exam: Marked tenderness at the acromioclavicular joint area as well as upon extension beyond 90degree.			

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 : 110 T : 36.7 HR : 75 RR : 22

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	M25.511	Pain in right shoulder
Secondary	G24.3	Spasmodic torticollis
Secondary	K21.9	Gastro-esophageal reflux disease without esophagitis

Type	Code	Diagnosis
Secondary	K29.00	Acute gastritis without bleeding
Secondary	E55.9	Vitamin D deficiency, unspecified

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:		

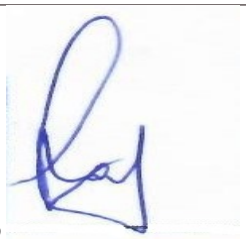
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	CONSULTATION GP	General Consultation	25.0000
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
73030	Radiologic examination, shoulder; complete, minimum of 2 views	Radiology	30.0000
82310	Calcium; total	Lab	10.0000
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Lab	100.0000
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
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) before meal
1217-373201-2401	(TOLPERISONE : 150 MG) SUGAR COATED TABLETS	15	Take 1Tablets 2 Time(s) per Day For 15 Day(s) after meal
2093-596002-0432	(DICLOFENAC DIETHYLAMINE : 23.2 MG / G) GEL	30	Take 1Gel 3 Time(s) per Day For 30 Day(s) others
0186-143701-0062	(CELECOXIB : 200 MG) CAPSULES	14	Take 1Tablets 2 Time(s) per Day For 14 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 : 25-Feb-2024
Note: Claims must be submited along with supportng 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 efects 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.