eASOAP FORM



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

ABDEL SATER ABD EL REHIM MOHAMED AHMED	Gender:	Male	Validity Between:	15/08/2023 and 14/08/2024
7BDE-2D43-9549-E33F	DOB:	6/12/1971 12:00:00 AM	Coverage Information for:	Out Patient
	Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
784-1971-9028061-6	Service Date:	27-Feb-2024	Radiology:	Covered
	Patent's Tel No:	505423053		
	Threshold Limit:			
ORIENT INSURANCE P.J.S.C	Class:	Normal		
	Out-Patent :			
Category B	Patent's File No:	31897	Pharmacy:	Co-Part: 20%
No	Consultaton :		Laboratory:	Covered
F 7	REHIM MOHAMED AHMED 7BDE-2D43-9549-E33F 784-1971-9028061-6 ORIENT INSURANCE P.J.S.C	REHIM MOHAMED AHMED 7BDE-2D43-9549-E33F DOB: Identty Card: Service Date: Patent's Tel No: Threshold Limit: Class: Out-Patent: Patent's File No:	REHIM MOHAMED AHMED 7BDE-2D43-9549-E33F DOB: Gender: Male 6/12/1971 12:00:00 AM Identty Card: 784-1971-9028061-6 Service Date: Patent's Tel No: Class: Class: Out-Patent: Patent's File No: Out-Patent: Patent's File No: 31897	REHIM MOHAMED AHMED Gender: Male Validity Between: Coverage Information for: Network: Network: Radiology: Patent's Tel No: P.J.S.C Category B Male Validity Between: Validity Between: Validity Between: Coverage Information for: Network: Radiology: Patent's Tel No: So5423053 Threshold Limit: Out-Patent: Patent's File No: Normal Pharmacy:

SUBJECTIVE ASSESSMENT

		Date of Symptoms/illness started		
Complaint	DD	MM	YYYY	
C/O BODY PAIN ,THROAT PAIN ,SNEEZING AND TOOTH ACHE SINCE 2 DAYS ON EXAMINATION PT HAS HYPREMIC THROAT AND MILD CONGESTION				

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Date of Symptoms/illness started Date of Symptoms/illness started DD MM YYYY Date of Symptoms/illness started DD MM YYYY And take did the Patient first feel same / similar Symptom(s) : dd mm yyyy s the Patient under any type of Treatment? Yes No if yes, indicate what Assessment and since when: DBJECTIVE / ASSESSMENT(To be completed by Physician) Clinical Findings: Vital Signs : B/P : 127 T : 36.7 HR : 78 RR : 22 Assessment/Diagnosis : Acute Chronic NDICATE DIAGNOSIS NOT SYMPTOM Type Code Diagnosis Primary J06.9 Acute upper respiratory infection, unspecified Secondary T78.40XA Allergy, unspecified, initial encounter ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury) Injury due	Past Medical Surgical History?			○ Yes			O No	Date o	Date of Symptoms/illness started			
DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD MM YYYY Para Gravida: AB: LMP: Marital Status: Marital Date: DD Marital Status: DD Marital Status: DD Marital Status: DD Marital Date: DD Marital Status: DD Marital Status: DD Marital Date: DD Marital Status: DD Mari						ONO	DD	MM	YYYY			
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Para Gravida: AB: LMP: Marital Status: Marital Date:	Obs/Gyn Claims											
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Secondary T78.40XA Allergy, unspecified, initial encounter ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or illness due to work? OYes ONO OYes ONO OYes ONO OTHER TRAINING OF Treatment OYes ONO OTHER OF OCONSULTATION OCONS	Para L	Gravida	1:	☐ AB:	LIVIP:	Maritai S	status:	ı'	viaritai Date:	_		
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Accident or illness due to work? Injury due to road accident?	Primary		J06.9		Acute	Acute upper respiratory infection, unspecified						
Accident or illness due to work? Injury due to road accident?	Secondary		T78.40X	A	Allergy	Allergy, unspecified, initial encounter						
Accident or illness due to work? To road accident? Describe how the accident or work related injury/illness occur:	ACCIDENT/OCCI	UPATION	AL Claim I	nformaton (omplete	if claim is	s a resu	lt of accide	nt or work related il	Iness/inju	ury)	
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s the following required O Surgery: O Endoscopy:	O Pharmacy:		Estmated Costs				O Laboratory / Radiology: Estmated Costs					
	Is the following	required		1	OSu	rgery:	O End	doscopy:				

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PI	O 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 & that the medical services shown on this form were medically indicated & necessary for the management of this case.	to release any informaton regarding my n	er, Insurer, Employer or other Organizaton medical conditon and history to NEXtCARE benefts. Medical management is the sole
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		
Signature & Stamp Dr. Sajid Sanaullah Khan General Practitioner DHA No: 05758224-001 PESHAWAR MEDICAL CENTER LLC DUBAI • U.A.E. Date:	Patient's Signature(Parent if minor) Date: 27-Feb-2024	
	I .	
Note: Claims must be submited along with supporting doc	uments within 30 days from date of servic	e

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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