

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	JUNAID KHAN HAZRAT HUSSAIN	Gender:	Male	Validity Between:	15/05/2023 and 14/05/2024
Card No:	0DEB-491B-010C-07B7	DOB:	4/1/1998 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1998-6788860-6	Service Date:	27-Feb-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0567004399		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	38568	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
C/O FEVER AND PAIN IN THROAT SINCE 2 DAYS								
BODY PAIN SINCE 2 DAYS								
NO KNOWN MEDICINE ALLERGIES								
ON EXAMINATION PT HAS HYPREMIC SORE THROAT WITH MILDLY INFLAMMED TONSILS								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:	DD	MM	YYYY
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 : 140 T : 36.6 HR : 74 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	J02.9	Acute pharyngitis, unspecified					
Secondary	R50.9	Fever, unspecified					
Secondary	R52	Pain, 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	GP Consultation	General Consultation	25.0000		
0005-111805-1021	CHLOROHISTOL 10MG-(CHLORPHENIRAMINE MALEATE : 10 MG/ML) SOLUTION FOR INJECTION	Pharmacy	1.2000		
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400		
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000		
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000		
Code	Generic	Duration	Instructions		
0005-119805-1173	(PREDNISOLONE : 5 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal		
0006-106601-0393	(PARACETAMOL : 500 MG) FILM COATED TABLETS	5	Take 2Tablets 3Time(s) perDay For 5 Day(s) after meal		
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others		
☐ 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 hereby certify 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 benefets. 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 : 27-Feb-2024			

Note: Claims must be submitted along with supporting documents within 30 days from date of service

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