eASOAP FORM

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

Patent Name:	**MUHAMMAD WASEEM**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**C044-C81F-DDDA-B6F6**	DOB:	**1/23/1986 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1986-6465819-6**	Service Date:	**27-Feb-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0568752391**		
Policy Holder:		Threshold Limit:			
Payer Name:	**DUBAI GOVERNMENT - PROGRAM 1 (ENAYA)**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42621**	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
Cough, pain in throat, fever and chest pain. A known asthmatic. Heavy smoker of at least 20 sticks per day			

Complaint
Known hypertensive and diabetic, claims good compliance.

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 : 145 T : 36.7 HR : 72 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J45.20	Mild intermittent asthma, uncomplicated
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
Secondary	I20.9	Angina pectoris, unspecified
Secondary	Z79.899	Other long term (current) drug therapy

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

Code	Generic	Duration	Instructions
0195-148602-0391	(CLARITHROMYCIN : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) after meal
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 Day(s) evening
0188-135906-2441	(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	60	Take 1Units 2 Time(s) per Day For 60 Day(s) others
0170-208601-1021	(INSULIN - GLARGINE : 100 IU/ML) SOLUTION FOR INJECTION	60	Take 42Units 1 Time(s) per Day For 60 Day(s) evening
0090-204901-0391	(SITAGLIPTIN (AS PHOSPHATE) : 50 MG) (METFORMIN HCL : 1000 MG) FILM COATED TABLETS	56	Take 1Tablets 2 Time(s) per Day For 56 Day(s) after meal
0188-155601-0391	(ROSUVASTATIN (AS CALCIUM) : 20 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0030-244101-0391	(CLOPIDOGREL : 75 MG) FILM COATED TABLETS	56	Take 1Tablets 1 Time(s) per Day For 56 Day(s) morning
0027-179203-0391	(AMLODIPINE : 5 MG) (VALSARTAN : 160 MG) FILM COATED TABLETS	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) morning

○ 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 : 27-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.