eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**LISA MAY MCMILLAN**	Gender:	**Female**	Validity Between:	**01/01/1900 and 13/04/2024**
Card No:	**21AF-69E6-4C09-D472**	DOB:	**3/20/1980 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1980-8737411-6**	Service Date:	**04-Mar-2024**	Radiology:	**Covered**
		Patent's Tel No:	**585185269**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41788**	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: Cough, pain in throat, with difficulty swallowing, Both ears also feels blocked. She is a known asthmatic and on regular steroid inhaler which she uses twice daily. and uses Ventolin inhaler. She is not a know hypertensive and not diabetic. Has allergies to most fruits, including apples, pear, cherry etc. ENT: Marked pharyngeal hyperemia. Both ears are normal on examination except for the presence of wax			

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 : 106	T : 36.8	HR : 78	RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J06.9	Acute upper respiratory infection, unspecified

Type	Code	Diagnosis
Secondary	J00	Acute nasopharyngitis [common cold]
Secondary	J30.9	Allergic rhinitis, unspecified
Secondary	J45.20	Mild intermittent asthma, uncomplicated

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

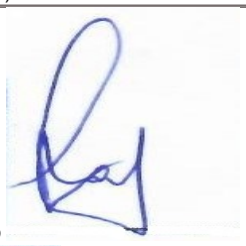
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
1204-571401-1161	(GUAIFENESIN : 100 MG/5ML) (PSEUDOEPHEDRINE HCL : 30 MG/5ML) (TRIPROLIDINE HCL : 1.25 MG/5ML) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal
4874-125821-3801	(POVIDONE IODINE : 0.45%) SPRAY SOLUTION	7	Take 1Spray 4Time(s) perDay For 7 Day(s) others
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	7	Take 2Tablets 1 Time(s) per Day For 7 Day(s) evening
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
2027-560101-0392	(IBUPROFEN : 150 MG) (PARACETAMOL : 500 MG) FILM COATED TABLETS	8	Take 1Tablets 2 Time(s) per Day For 8 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 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 : 04-Mar-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		

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