eASOAP FORM

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

Patent Name:	**RAWAN AZZAM MOHAMMAD YACOUB**	Gender:	**Female**	Validity Between:	**28/02/2024 and 27/02/2025**
Card No:	**81BA-D6A7-17F9-E055**	DOB:	**6/24/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1996-1494925-5**	Service Date:	**04-Mar-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0566214040**		
Policy Holder:		Threshold Limit:			
Payer Name:	**Islamic Arab Insurance Co. (P.S.C.**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**38988**	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

Complaint

G2, Para 1.

LMP: 06/11/2023.

C/o: weakness.

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 : 109 T : 36.7 HR : 86 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	D50.9	Iron deficiency anemia, unspecified
Secondary	N39.0	Urinary tract infection, site not specified
Secondary	Z3A.20	20 weeks gestation of pregnancy
Secondary	E56.9	Vitamin deficiency, unspecified
Secondary	E03.9	Hypothyroidism, 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

Code	Generic	Duration	Instructions
1504-480601-0051	(CALCIUM (AS CALCIUM CARBONATE) : 600 MG) (BORON (AS SODIUM BORATE) : 250 MCG) (COPPER (AS CUPRIC OXIDE) : 1 MG) (MANGANESE (AS MANGANESE SULPHATE) : 1.8 MG) (ZINC (AS ZINC OXIDE) : 7.5 MG) (MAGNESIUM(AS MAGNESIUM OXIDE) : 40 MG) (VITAMIN D (AS D3) : 200 IU) CAPLETS	90	Take 1Tablets 1 Time(s) per Day For 90 Day(s) evening
5831-879401-0061	(VITAMIN B12 : 2.5 MCG) (FOLIC ACID : 1 MG) (FERRIC PYROPHOSPHATE : 30 MG) CAPSULES	60	Take 1Tablets 1 Time(s) per Day For 60 Day(s) evening
0444-348905-0971	(CHOLECALCIFEROL : 10000 IU) SOFT GELATIN CAPSULES	90	Take 1Tablets 2 Time(s) per Day For 90 Day(s) evening
0252-182201-0081	(FOLIC ACID : 0.35 MG) (IRON (AS FERRIC/FERROUS HYDROXIDE POLYMALTOSE COMPLEX) : 100 MG) CHEWABLE TABLETS	90	Take 1Tablets 1 Time(s) per Day For 90 Day(s) evening

○ 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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