eASOAP FORM

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

Patent Name:	**ARVIND TIWARI VIRENDRA PRASAD TIWARI**	Gender:	**Male**	Validity Between:	**30/03/2023 and 29/03/2024**
Card No:	**E775-40AD-FE2B-2116**	DOB:	**2/5/1989 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1989-1399990-4**	Service Date:	**05-Mar-2024**	Radiology:	**Covered**
		Patent's Tel No:	**971556339080**		
Policy Holder:		Threshold Limit:			
Payer Name:	**UNION INSURANCE COMPANY**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**40133**	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
pt has pain in upper right front area of mouth while eating since 6 days								
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 : 35 HR : 68 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	S02.5XXS	Fracture of tooth (traumatic), sequela
Secondary	K04.7	Periapical abscess without sinus

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

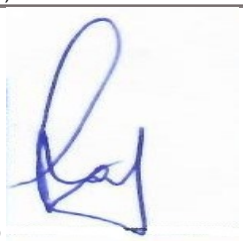
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
0170-116609-1171	(METRONIDAZOLE : 400 MG) TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) after meal
0015-107903-0391	(IBUPROFEN : 600 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) after meal
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others
0005-252201-0391	(CAFFEINE : 65 MG) (IBUPROFEN : 400 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0015-107903-0391	(IBUPROFEN : 600 MG) FILM COATED TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) after meal
0170-116609-1171	(METRONIDAZOLE : 400 MG) TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 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 : 05-Mar-2024	
Note: Claims must be submited along with supportng documents within 30 days from date of service		