eASOAP FORM

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

Patent Name:	**AISHA NOREAN**	Gender:	**Female**	Validity Between:	**20/02/2024 and 19/02/2025**
Card No:	**BBAD-4501-76AD-92A4**	DOB:	**1/7/1982 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1982-9507615-6**	Service Date:	**21-Mar-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0527327673**		
Policy Holder:		Threshold Limit:			
Payer Name:	**TAKAFUL EMARAT**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**42797**	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: Feeling of discomfort on the left breast since yesterday afternoon. There was no history of trauma and no physical injury. Character could not be adequately described but feels like pressure, and it is not aggravated by touch, by change in posture. Has had this feeling of two previous occasions 2 years ago for which she was reassured it was due to stress. She is not a known hypertensive and not diabetic, has no past medical condition but has a family history of cardiac condition in the father who had a silent MI at 66years. Father was not hypertensive. There is no previous history of breast conditions, and no family history of same. ECG and cardiac enzymes is advised. ECG done showed mild bradycardia of 55bpm, but all other findings essentially normal.			

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 : 120 T : 36.8 HR : 82 RR : 18

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R07.9	Chest pain, unspecified
Secondary	M94.0	Chondrocostal junction syndrome [Tietze]

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
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Co.Pay	40.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
86140	C-reactive protein;	Lab	15.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
84484	Troponin, quantitative	Lab	35.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0027-149903-0391	(DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 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 : **Enomen Goodluck**		
Tel / Fax (important):		
Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 20040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***	
Date :	Date : 21-Mar-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.