

## eASOAP FORM



## ADMINISTRATIVE

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

|                   |                                            |                   |                             |                          |                                       |
|-------------------|--------------------------------------------|-------------------|-----------------------------|--------------------------|---------------------------------------|
| Patent Name:      | <b>HAZEM SAMER BARAKA<br/>SAMER BARAKA</b> | Gender:           | <b>Male</b>                 | Validity Between:        | <b>15/01/2024 and 14/01/2025</b>      |
| Card No:          | <b>C68E-228E-8DBB-D55C</b>                 | DOB:              | <b>1/4/1999 12:00:00 AM</b> | Coverage Informaton for: | <b>Out Patient</b>                    |
| Pin #:            |                                            | Identty Card:     |                             | Network:                 | <b>RN UAE (Al Ansari-AUH)-MEDGULF</b> |
| Natonal ID:       | <b>784-1999-0248696-0</b>                  | Service Date:     | <b>27-Mar-2024</b>          | Radiology:               | <b>Covered</b>                        |
| Policy Holder:    |                                            | Patent's Tel No:  | <b>0522827398</b>           |                          |                                       |
| Payer Name:       | <b>ORIENT INSURANCE<br/>P.J.S.C</b>        | Class:            | <b>Normal</b>               |                          |                                       |
| Category:         | <b>Category B</b>                          | Out-Patent :      |                             | Pharmacy:                | <b>Co-Part: 20%</b>                   |
| Gatekeeper:       | <b>No</b>                                  | Patent's File No: | <b>42819</b>                | Laboratory:              | <b>Covered</b>                        |
| Referral No:      |                                            | Consultaton :     |                             |                          |                                       |
| Referred Service: |                                            |                   |                             |                          |                                       |

## SUBJECTIVE ASSESSMENT

|                                                                                                                                                  |  |  |  |  |  |                                         |    |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|-----------------------------------------|----|------|
| <b>Symptom(s) as described by the patent (Chief Complaint):</b>                                                                                  |  |  |  |  |  | <b>Date of Symptoms/illness started</b> |    |      |
| <b>Complaint</b>                                                                                                                                 |  |  |  |  |  | DD                                      | MM | YYYY |
| Pain in throat since 2 days,<br>associated cough and fever.<br>Has no other significant past medical history, not hypertensive and not diabetic. |  |  |  |  |  |                                         |    |      |
| <b>Past Medical Surgical History?</b>                                                                                                            |  |  |  |  |  | <b>Date of Symptoms/illness started</b> |    |      |
| <input type="radio"/> Yes <input type="radio"/> No                                                                                               |  |  |  |  |  | DD                                      | MM | YYYY |
| <b>Obs/Gyn Claims</b>                                                                                                                            |  |  |  |  |  | <b>Date of Symptoms/illness started</b> |    |      |
| <input type="checkbox"/> Para <input type="checkbox"/> Gravida: <input type="checkbox"/> AB: LMP: Marital Status: Marital Date:                  |  |  |  |  |  | DD                                      | MM | YYYY |
| What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy                                                                      |  |  |  |  |  |                                         |    |      |
| Is the Patient under any type of Treatment? <input type="radio"/> Yes <input type="radio"/> No if yes, indicate what Assessment and since when:  |  |  |  |  |  |                                         |    |      |

## OBJECTIVE / ASSESSMENT (To be completed by Physician)

|                                                                                                                                                                                                  |             |                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------|--|
| <b>Clinical Findings :</b>                                                                                                                                                                       |             | Vital Signs : B/P : 108 T : 36 HR : 82 RR : 22 |  |
| <b>Assessment/Diagnosis :</b> <input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Confirmed <input type="radio"/> Suspected<br><b>INDICATE DIAGNOSIS NOT SYMPTOM</b> |             |                                                |  |
| <b>Type</b>                                                                                                                                                                                      | <b>Code</b> | <b>Diagnosis</b>                               |  |
| Primary                                                                                                                                                                                          | J03.00      | Acute streptococcal tonsillitis, unspecified   |  |
| Secondary                                                                                                                                                                                        | J30.9       | Allergic rhinitis, unspecified                 |  |
| Secondary                                                                                                                                                                                        | R50.9       | Fever, unspecified                             |  |

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

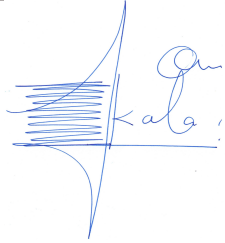
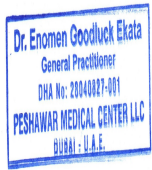
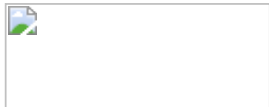
|                                                    |                                                    |                                                                 |
|----------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------|
| Accident or illness due to work?                   | Injury due to road accident?                       | Describe how the accident or work related injury/illness occur: |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> 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   |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------|
| 96375            | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) | Co.Pay               | 5.0000  |
| 96372            | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular                                                                                                   | Co.Pay               | 10.0000 |
| 0125-122107-1022 | DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION                                                                                                                                 | Pharmacy             | 2.3400  |
| 0005-149902-1021 | CLOFEN                                                                                                                                                                                                          | Pharmacy             | 6.5000  |
| 0195-107704-0801 | CEFTRIAXONE-TABUK IV                                                                                                                                                                                            | Pharmacy             | 48.5000 |
| 96365            | Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour                                                                                                 | Co.Pay               | 40.0000 |
| 9                | GP Consultation                                                                                                                                                                                                 | General Consultation | 25.0000 |
| 87070            | Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates                                                                           | Lab                  | 25.0000 |
| 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 |

| Code             | Generic                                                                                                                                     | Duration | Instructions                                             |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------|----------------------------------------------------------|
| 0207-142902-1451 | (CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)                                                                                                 | 7        | Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal  |
| 4874-125821-3801 | (POVIDONE IODINE : 0.45%) SPRAY SOLUTION                                                                                                    | 5        | Take 1Spray 4 Time(s) per Day For 5 Day(s) after meal    |
| 1516-107902-1171 | (IBUPROFEN : 400 MG) TABLETS                                                                                                                | 5        | Take 1Tablets 2 Time(s) per Day For 5 Day(s) after meal  |
| 0005-116801-2481 | (SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP (SUGAR FREE) | 7        | Take 10ML 3 Time(s) per Day For 7 Day(s) after meal      |
| 0195-123701-0391 | (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS                                                                                                | 10       | Take 1Tablets 1Time(s) perDay For 10 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 |

|                                 |                                      |                                               |                 |
|---------------------------------|--------------------------------------|-----------------------------------------------|-----------------|
| <input type="radio"/> Pharmacy: | Estimated Costs                      | <input type="radio"/> Laboratory / Radiology: | Estimated Costs |
| Is the following required       | <input type="radio"/> Surgery:       | <input type="radio"/> Endoscopy:              |                 |
|                                 | <input type="radio"/> Physiotherapy: | <input type="radio"/> Other Procedures:       |                 |
|                                 | If yes please specify                |                                               |                 |

| Is In-patient Required ? Length of Stay                                                                                                                                                                                                                                                                                                                                                                                                                                              | Indicate Provider | Estimate Cost |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------|
| <i>I hereby certify that all informaton mentoned are correct &amp; that the medical services shown on this form were medically indicated &amp; necessary for the management of this case.</i>                                                                                                                                                                                                                                                                                        |                   |               |
| <i>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 benefsts. Medical management is the sole responsibility of doctor and the patent.</i>                                                                                                                                                                                 |                   |               |
| Treating Physician Name : <b>Enomen Goodluck</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   |               |
| Tel / Fax (important):                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   |               |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p><i>Signature &amp; Stamp</i></p>   </div> <div style="width: 55%;"> <p><i>Patient's Signature(Parent if minor)</i></p>  </div> </div> |                   |               |
| Date :                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   |               |
| Date : 27-Mar-2024                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                   |               |
| Note: Claims must be submitted along with supporting 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.