eASOAP FORM

NEXTCARE® Your Health Managed with Care

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

Patent Name:	**JANE KADOGO NDUNGE**	Gender:	**Female**	Validity Between:	**09/02/2024 and 08/02/2025**
Card No:	**1C75-4DA3-F9AA-AF9F**	DOB:	**1/31/1979 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1979-6259602-5**	Service Date:	**30-Mar-2024**	Radiology:	**Covered**
		Patent's Tel No:	**529907341**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**41884**	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: still has pain in throat, still has cough that is worse at night. Also has bilateral kneel pain especially on climbing the stairs. Pain also on the left upper chest. Does not radiate and there is no palpitation nor weakness. Known hyperthyroid patient. Also obese with a BMI of 33.6. Not hypertensive and not diabetic.			

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 : 124 T : 36.8 HR : 84 RR : 22

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

Type	Code	Diagnosis
Primary	J02.8	Acute pharyngitis due to other specified organisms
Secondary	J03.90	Acute tonsillitis, unspecified
Secondary	M17.0	Bilateral primary osteoarthritis of knee
Secondary	M94.0	Chondrocostal junction syndrome [Tietze]

Type	Code	Diagnosis
Secondary	E04.9	Nontoxic goiter, unspecified
Secondary	K21.00	Gastro-esophageal reflux dis with esophagitis, without bleed
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:
○ 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	GP Consultation	General Consultation	25.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
84439	Thyroxine; free	Lab	30.0000
84481	Triiodothyronine T3; free	Lab	40.0000
84443	Thyroid stimulating hormone (TSH)	Lab	40.0000

Code	Generic	Duration	Instructions
1504-513601-1171	(ZINC : 3.75 MG) (METHYLSULFONYLMETHANE : 375 MG) (HYALURONIC ACID : 20 MG) (ASCORBIC ACID (VITAMIN C) : 25 MG) (COPPER : 125 MCG) (MANGANESE : 1.25 MG) (MOLYBDENUM : 55 MCG) (MAGNESIUM : 50 MG) (GLUCOSAMINE : 375 MG) (FLEXICOL PROPRIETARY BLEND : 241.25 MG) TABLETS	60	Take 1Tablets 2Time(s) perDay For 60 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
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) evening
0188-232401-0392	(ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS	1	Take 1 Unit(s), 1 Time(s) per Day For 1 Day(s)
1945-547902-1171	(CHONDROITIN : 400 MG) (GLUCOSAMINE : 500 MG) (METHYLSULPHONYL-METHANE (MSM) : 166.66 MG) (HYALURONIC ACID : 10 MG) TABLETS	60	Take 1Tablets 2Time(s) perDay For 60 Day(s) after meal
0090-265901-1171	(MONTELUKAST : 10 MG) TABLETS	30	Take 1Tablets 1Time(s) perDay For 30 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
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0137-148602-0391	(CLARITHROMYCIN : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 2Time(s) perDay 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 : **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 : 30-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.