

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	MALIK MUHAMMAD ASHRAF WARRAICH UBAID ULLAH	Gender:	Male	Validity Between:	24/03/2024 and 23/03/2025
Card No:	0430-067C-5577-FBF3	DOB:	3/8/1980 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1980-8279825-1	Service Date:	30-Mar-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0529664671		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	34836	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint Pain on the right foot since yesterday said to have mistakenly hit his foot against a brick step while climbing the stairs. Now has pain on walking and unable to press the foot firmly to the ground. Exam: tenderness over the medial aspect of the calcaneal bone. there is no limitation in the range of ankle joint movement. No obvious injury and no swelling.						DD	MM	YYYY
Past Medical Surgical History?			☐ Yes	☐ No	Date of Symptoms/illness started			
					DD	MM	YYYY	
Obs/Gyn Claims			Date of Symptoms/illness started					
☐ Para	☐ Gravida:	☐ 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? ☐ Yes ☐ No if yes, indicate what Assessment and since when:								

OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :			Vital Signs : B/P : 110	T : 39	HR : 100	RR : 22
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	S92.025A	Nondisp fx of anterior process of left calcaneus, init				
Secondary	G89.11	Acute pain due to trauma				

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

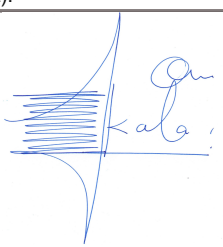
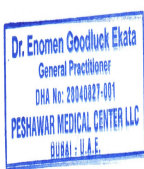
Accident or illness due to work? ☐ Yes ☐ No	Injury due to road accident? ☐ Yes ☐ No	Describe how the accident or work related injury/illness occur:
Date of accident or beginning of illness:		

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
73600	Radiologic examination, ankle; 2 views	Radiology	30.0000
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0426-160701-2541	(METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY	10	Take 1Spray 4 Time(s) per Day For 10 Day(s) after meal
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:	Estimated Costs	☐ Laboratory / Radiology:	Estimated 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>I hereby certify 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>		<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 benefets. Medical management is the sole responsibility of doctor and the patent.</i>
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
 Signature & Stamp 		 Patient's Signature(Parent if minor)
Date :	Date : 30-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 effects 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.