

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	TAMER MOHAMED	Gender:	Male	Validity Between:	15/01/2024 and 14/01/2025
Card No:	F942-5B7F-31B0-5B3D	DOB:	8/9/1984 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natnol ID:	784-1984-2479532-0	Service Date:	02-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0586404511		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	42562	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

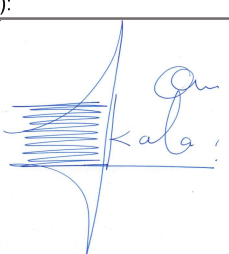
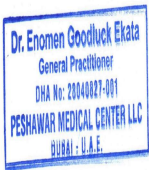
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):					Date of Symptoms/illness started		
Complaint					DD	MM	YYYY
Headache, pain in throat, cough and fever.							
Past Medical Surgical History?				☐ Yes	☐ No	Date of Symptoms/illness started	
						DD	MM
						MM	YYYY
Obs/Gyn Claims				Date of Symptoms/illness started			
						DD	MM
						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 : 117		T : 37.4	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	J01.00	Acute maxillary sinusitis, unspecified				
Secondary	J22	Unspecified acute lower respiratory infection				
Secondary	E78.5	Hyperlipidemia, unspecified				
Secondary	N40.1	Benign prostatic hyperplasia with lower urinary tract symp				

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
Code	Generic	Duration	Instructions		
1700-504301-1451	(DUTASTERIDE : 0.5 MG) (TAMSULOSIN HCL : 0.4 MG) CAPSULES (HARD GELATIN)	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening		
1233-211703-0393	(ATORVASTATIN : 20 MG) FILM COATED TABLETS	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) evening		
0027-128802-2021	(XYLOMETAZOLINE HYDROCHLORIDE : 0.1%) NASAL DROPS	5	Take 1Drops 2 Time(s) per Day For 5 Day(s) others		
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 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		
5363-393801-1161	(DIPHENHYDRAMINE HCL : 13.5 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) SYRUP	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 1 Time(s) per Day 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		
☐ 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 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 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 benefits. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : Enomen Goodluck					
Tel / Fax (important):					
 Signature & Stamp 		 Patient's Signature(Parent if minor)			
Date :		Date : 02-Apr-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 creation 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 final opinion will be given by the NEXtCARE claims doctors.