

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	GEEKIYANAGE NILANKA JUDE GAYAN FERNANDO		Gender:	Male	Validity Between:	20/09/2023 and 19/09/2024
Card No:	5A86-73DA-5D2E-275C		DOB:	3/9/1972 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:			Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1972-0361037-9		Service Date:	02-Apr-2024	Radiology:	Covered
Policy Holder:			Patent's Tel No:	971554495529		
Payer Name:	ORIENT INSURANCE P.J.S.C		Threshold Limit:			
			Class:	Normal		
Category:	Category B		Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No		Patent's File No:	39009	Laboratory:	Covered
Referral No:			Consultation :			
Referred Service:						

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
Cough since the past 4 days.								
Cough is productive of clear sputum.								
There is associated low grade fever,								
No chest pain and no difficulty breathing								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	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 : T : HR : RR :		
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected					
INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	J22	Unspecified acute lower respiratory infection			
Secondary	J20.9	Acute bronchitis, unspecified			

Type	Code	Diagnosis
Secondary	R05	Cough
Secondary	R50.81	Fever presenting with conditions classified elsewhere

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:		

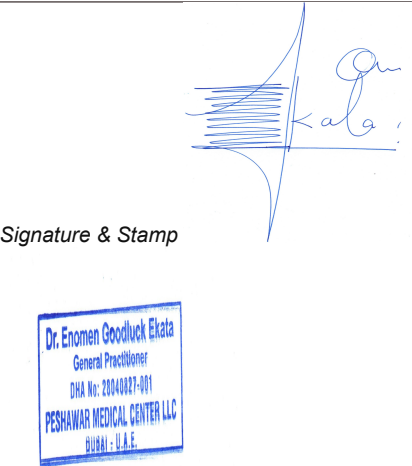
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
9	GP Consultation	General Consultation	25.0000
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates	Lab	25.0000
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza	Lab	30.0000
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
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 2Tablets 1 Time(s) per Day For 5 Day(s) evening
0097-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1ML 1 Time(s) per Day For 5 Day(s) others
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
0252-389802-1171	(PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE HCL : 30 MG) TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 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>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 : 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.