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 Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1972-0361037-9**	Service Date:	**04-Apr-2024**	Radiology:	**Covered**
		Patent's Tel No:	**971554495529**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**39009**	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
Represented as he could not get his medications due to insurrance bottle necks. medicines deprescribed and diagnosis reviewed.			

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 : 145 T : 37.3 HR : 78 RR : 0

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

Type	Code	Diagnosis
Secondary	I10	Essential (primary) hypertension

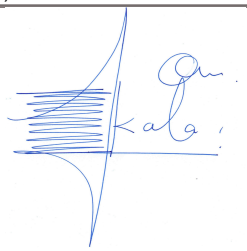
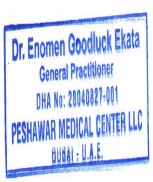
ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)		
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
○ Yes ○ No	○ Yes ○ No	
Date of accident or beginning of illness:		

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
0046-149907-1141	(DICLOFENAC SODIUM : 75 MG) SUSTAINED RELEASE TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
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
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
0027-265802-1161	(BUTAMIRATE DIHYDROGEN CITRATE : 0.15% W/V) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) others
0097-127405-0391	(AZITHROMYCIN : 500 MG) FILM COATED TABLETS	5	Take 1ML 1 Time(s) per Day For 5 Day(s) others
0005-119805-1172	(PREDNISOLONE : 5 MG) TABLETS	5	Take 2Tablets 1 Time(s) per Day For 5 Day(s) evening
2763-379201-1451	(AMLODIPINE (AS BESYLATE) : 5 MG) CAPSULES (HARD GELATIN)	28	Take 1Tablets 1 Time(s) per Day For 28 Day(s) others

○ 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  	***Patient's Signature(Parent if minor)*** 	

Date :	Date : 04-Apr-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	