eASOAP FORM



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

Patent Name:	DIANA ABDELAZIZ	Gender:	Female	Validity Between:	26/03/2024 and 25/03/2025
Card No:	69EA-B2BD-F221-BF9A	DOB:	12/29/1992 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)- MEDGULF
Natonal ID:	784-1992-2988493-9	Service Date:	06-Apr-2024	Radiology:	Covered
		Patent's Tel No:	0585450344		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	40555	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					
SUBJECTIVE ASSE	SSMENT				

Symptom(s)) as described by the p	atent (Chief	Complaint'	.):			Date o	of Symptoms/il	Iness started
Complaint								MM	YYYY
Recurrent	headaches and vomiti	ng, for which	າ she had 3	3 episodes las	st night.				
A known m	nigraine patient.								
Took tylen	ol last night but heada	iche has pers	isted.						
it is severe	e enough to make her s	skip work.							
There is no	o fever.							+	+
Doot Madica	-l Consisal History			○Yes		T _{ON}	Date	of Symptoms/i	Ilness started
Past ivieuica	al Surgical History?		!	Yes		O No	DD	MM	YYYY
							Date o	of Symptoms/i	 illness started
Obs/Gyn Cla	ims						DD	MM	YYYY
☐ Para	☐ Gravida:	□ АВ:	LMP:	Marital Statu	us:	Marital Date:			
What date did	d the Patient first feel sa	ame / similar :	Symptom(s`) : dd mm yyş					
Is the Patient	t under any type of Treat	itment? O Ye	es O No	if yes, indica	ate what Asse	ssment and since	when:		
OBJECTIVE	/ ASSESSMENT(To be	completed by	/ Physician)	,					
Clinical Find	lings :				Vital Signs : : 18	B/P: 115	T:36.4	HR : 65	RF
	t/Diagnosis : O Ac INDICATE DIAGNOSIS		⁾ Chronic ГОМ	O Confirme	ned OSusp	pected			
Туре	Code	Diag	nosis						
Primary	G43.119	D. 41		aura, intractal					

ness: nvoices and nent nsultation	Injury due t accident? Yes 1 Applicable P	f claim is a to road No Prescription	Dens / Re	escribe how eports / Res	the accident or work ults must be enclose	related inju		
ness: nvoices and nent nsultation MOL: 500 I	Injury due t accident? Yes 1 Applicable P	to road No Prescription	Dens / Re	escribe how eports / Res eral Consulta	the accident or work ults must be enclose	related inju	· claim Price	
nvoices and ment nsultation MOL: 500 I	accident? Yes O	No Prescription	ns / Re	eports / Res eral Consulta	ults must be enclose ation	·	· claim Price	
nvoices and ment nsultation MOL: 500 I	Applicable P	Prescription	Туре	eral Consulta	ation	d to consider	Price	
nvoices and ment nsultation MOL: 500 I			Туре	eral Consulta	ation	d to consider	Price	
nsultation MOL: 500 I			Туре	eral Consulta	ation	d to consider	Price	
nsultation MOL : 500 I	MG) FILM CO	DATED		eral Consulta				
MOL : 500 I	MG) FILM CO	DATED	Gene	I I			25.0000	
	MG) FILM CO	DATED		Duration	Instructions			
	MG) FILM CO	DATED		Duration	Instructions			
	MG) FILM CO	DATED						
PTAN : 100 N	106601- (PARACETAMOL : 500 MG) FILM CO TABLETS				Take 2Tablets 3 Tim meal	e(s) per Day For 3 Day(s) after		
0006-199803- 1172 (SUMATRIPTAN : 100 MG) TABLETS				5	Take 1Tablets 1 Tim	e(s) per Day For 5 Day(s) evening		
Estmated	Costs		C	O Laboratory / Radiology:		Estmated Costs		
O Surger	ry:		С	Endoscopy	y:			
O Physic	Physiotherapy:			Other Procedures:				
			lf y	yes please s	pecify			
21/			In	ndicate Provid	der		Estimate Cost	
	are correct	I hereby au				er, Employer		
							_	
r the manag						ledical mana	gement is the sole	
	/	responsibi	lity of	doctor and	the patent.			
Goodluck								
Que.								
n n fo	O Physicostay n mentoned on this form	n mentoned are correct n on this form were for the management of n Goodluck	Physiotherapy: O Physiotherapy: I hereby a release an release an the purpose responsibility of the management of the purpose responsibility of the purpose	Physiotherapy: If Stay Ir In mentoned are correct In on this form were For the management of In Goodluck I hereby authoric release any info the purpose of corresponsibility of	Other Pro If yes please s Stay Indicate Provious In mentoned are correct on on this form were For the management of the purpose of determining responsibility of doctor and the purpose of doctor and	Other Procedures: If yes please specify Indicate Provider In mentoned are correct In on this form were For the management of the purpose of determining insurance benefts. Management In Goodluck Other Procedures: In dicate Provider In hereby authorize any Healthcare Provider, Insurate lease any information regarding my medical containing insurance benefts. Management In Goodluck	Other Procedures: If yes please specify Indicate Provider In mentoned are correct on on this form were For the management of the purpose of determining insurance benefts. Medical management of the purpose of doctor and the patent. In Goodluck Other Procedures: If yes please specify Indicate Provider I hereby authorize any Healthcare Provider, Insurer, Employer release any information regarding my medical condition and he purpose of determining insurance benefts. Medical management of the purpose of doctor and the patent.	

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 final opinion will be given by the NEXtCARE claims doctors.

Date: 06-Apr-2024

Note: Claims must be submited along with supporting documents within 30 days from date of service

Patient's Signature(Parent if minor)