

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	NAVDHA ARORA	Gender:	Female	Validity Between:	01/01/1900 and 19/09/2024
Card No:	1EA9-7D53-3181-852B	DOB:	8/19/2018 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2018-3869600-9	Service Date:	08-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	058 560 1705		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	41708	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultation :		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
C/o: Upper abdominal pain, vomiting for which she had 6 episodes today. Also has fever, temperature at presentation is 37.8 degree celcius. There is no diarrhea, General exam: Febrile (37.8degree) and moderately dehydrated. ENT: hyperemia of the pharyngotonsils. Marked epigastric tenderness. Parents declined IV treatment.								
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 : 0			T : 37.8		HR : 98		RR : 0	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected											
INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	J02.9	Acute pharyngitis, unspecified									

Type	Code	Diagnosis
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R50.9	Fever, unspecified
Secondary	R11.10	Vomiting, unspecified

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

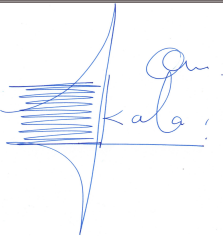
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
0005-196702-1161	(PROMETHAZINE : 5 MG/5ML) SYRUP	3	Take 5ML 3Time(s) perDay For 3 Day(s) others
0006-106607-1161	(PARACETAMOL : 240 MG/5ML) SYRUP	5	Take 7.5ML 3Time(s) perDay For 5 Day(s) after meal
0188-232403-0461	(ESOMEPRAZOLE : 10 MG) GRANULES FOR RECONSTITUTION	7	Take 1Powder 2 Time(s) per Day For 7 Day(s) before meal
0325-142903-0851	(CEFIXIME : 100 MG/5ML) POWDER FOR SUSPENSION	7	Take 10ML 1Time(s) perDay For 7 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 : 08-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 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 fnal opinion will be given by the NEXtCARE claims doctors.