eASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patent Name:	**RITIKA DAS**	Gender:	**Female**	Validity Between:	**01/10/2023 and 30/09/2024**
Card No:	**75F7-370E-079D-008A**	DOB:	**1/1/1996 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1995-5876360-5**	Service Date:	**12-Apr-2024**	Radiology:	**Covered**
		Patent's Tel No:	**559774152**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ORIENT INSURANCE P.J.S.C**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**33411**	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
Diarrhea and abdominal pain since this morning Has had 7 episodes of diarrhea. She has not vomited but has nausea. Abdominal pain is located above the naval and is relieved following defecation. She has a slight low grade fever			

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 : 92	T : 37.6	HR : 77	RR : 20

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**
INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	R19.7	Diarrhea, unspecified
Secondary	K29.00	Acute gastritis without bleeding
Secondary	R50.9	Fever, 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
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
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
0005-136504-1021	SCOPINAL	Pharmacy	4.6000
0005-242802-0781	PANTONIX 40MG I.V.	Pharmacy	29.5000
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0097-230603-2091	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) ORAL POWDER	3	Take 1Solution 1Time(s) perDay For 3 Day(s) others
0415-200001-1452	(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	1	Take 2 tablets one time only and then 1 after every loose stool. DO NOT take more than 4 tablets per day
0042-136501-1173	(HYOSCINE : 10 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) before meal
0188-232402-0392	(ESOMEPRAZOLE : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 2Time(s) perDay For 7 Day(s) before 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 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 Dr. Enomen Goodluck Ekata General Practitioner DHA No: 20040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI : U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 12-Apr-2024
Note: Claims must be submited along with supportng 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.