

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	Mehyeddine Saady	Gender:	Male	Validity Between:	12/09/2023 and 11/09/2024
Card No:	DF30-3D92-7D41-F7FF	DOB:	3/17/1987 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1987-9538165-0	Service Date:	18-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0586444308		
		Threshold Limit:			
Payer Name:	MEDGULF - THE MEDITERRANEAN and GULF INSURANCE and REINSURANCE CO. B.S.C. (C) (DUBAI BRANCH)	Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	42920	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started			
Complaint						DD	MM	YYYY	
Pain and swelling on the right hand since one hour prior to presentation.									
Fell down while working out.									
Has no other medical condition, not hypertensive and not diabetic.									
Exam: deformity of the 5th metacarpophalyngeal joint and associated swelling at the dorsum..									
There is however no limitation of movement.									
X-ray is advised.									
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 : 81	T : 36.8	HR : 78	RR : 18
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected						
INDICATE DIAGNOSIS NOT SYMPTOM						
Type	Code	Diagnosis				
Primary	S63.8X1A	Sprain of other part of right wrist and hand, init encntr				

Type	Code	Diagnosis
Secondary	G89.11	Acute pain due to trauma

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

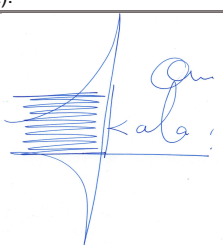
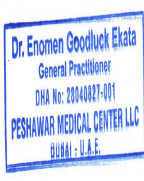
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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
73120	Radiologic examination, hand; 2 views	Radiology	30.0000

Code	Generic	Duration	Instructions
0426-160701-2541	(METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY	10	Take 1Spray 2 Time(s) per Day For 10 Day(s) others
0027-149903-0391	(DICLOFENAC SODIUM : 100 MG) FILM COATED TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 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 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 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.		
Treating Physician Name : Enomen Goodluck		
Tel / Fax (important):		
 Signature & Stamp 	Patient's Signature(Parent if minor) 	
Date :	Date : 18-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 effects 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.