

eASOAP FORM


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

Patent Name:	MUHAMMAD AWAIS	Gender:	Male	Validity Between:	25/09/2023 and 24/09/2024
Card No:	87BD-76D4-ABA4-54BC	DOB:	4/15/2024 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-2001-9826723-7	Service Date:	19-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0526659064		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
Category:	Category B	Out-Patient :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	42922	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
co fever and bodyache 2 days loose motion 2 days abdominal discomfort 2 days							
oe ill looking weak throat clear dehydrated abdominal pain mild							
Past Medical Surgical History?					Date of Symptoms/illness started		
☐ Yes ☐ No					DD	MM	YYYY
Obs/Gyn Claims					Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:					DD	MM	YYYY
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 : 138 T : 37.8 HR : 111 RR : 18			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	R50.9	Fever, unspecified					
Secondary	R19.7	Diarrhea, unspecified					
Secondary	R12	Heartburn					
Secondary	R53.1	Weakness					

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:		

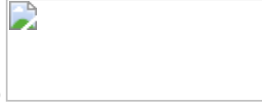
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
9	GP Consultation	General Consultation	25.0000

Code	Generic	Duration	Instructions
0011-179001-1171	(CAFFEINE : 65 MG) (PARACETAMOL : 250 MG) (ASPIRIN : 250 MG) TABLETS	7	Take 2Tablets 4 Time(s) per Day For 7 Day(s) others
0669-533801-0391	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
1795-502202-1451	(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others
7020-993001-1171	(VITAMIN B12 (CYANOCOBALAMIN) : 18 MCG) (VITAMIN D3 (CHOLECALCIFEROL) : 5 MCG) (VITAMIN E : 26.84 MG) (VITAMIN K1 : 25 MCG) (VITAMIN C (ASCORBIC ACID) : 120 MG) (BIOTIN : 40 MCG) (FOLIC ACID : 0.4 MG) (PANTOTHENIC ACID : 10 MG) (IODINE (AS POTASSIUM IODIDE) : 0.15 MG) (CALCIUM (AS CARBONATE + CALCIUM PHOSPHATE DIBASIC) : 100 MG) (PHOSPHORUS (AS CALCIUM PHOSPHATE DIBASIC) : 48 MG) (MAGNESIUM OXIDE : 45 MG) (IRON (FERROUS FUMARATE) : 14 MG) (COPPER SULFATE : 0.7 MG) (MANGANESE SULFATE : 4 MG) (CHR	30	Take 1Tablets 1 Time(s) per Day For 30 Day(s) others
0724-107002-1171	(CAFFEINE : 60 MG) (PARACETAMOL : 500 MG) TABLETS	3	Take 2Tablets 4 Time(s) per Day For 3 Day(s) others
0097-230603-0832	(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	5	Take 1Tablets 1 Time(s) per Day For 5 Day(s) others
0102-103201-0391	(CIPROFLOXACIN : 500 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
4651-502501-1451	(BISMUTH SUBCITRATE POTASSIUM : 140 MG) (TETRACYCLINE HYDROCHLORIDE : 125 MG) (METRONIDAZOLE : 125 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others

☐ 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 benefsts. Medical management is the sole responsibility of doctor and the patent.	
Treating Physician Name : Sajid Sanaullah		
Tel / Fax (important):		

 Signature & Stamp 	 Patient's Signature(Parent if minor)
Date :	Date : 19-Apr-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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