

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	NI NYMON PERAWATI	Gender:	Female	Validity Between:	05/10/2023 and 04/10/2024
Card No:	6A0B-286A-F655-7DD1	DOB:	10/10/1981 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
National ID:	784-1981-6020535-1	Service Date:	23-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0565542803		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patient :			
Category:	Category B	Patent's File No:	42953	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
co dizziness vomiting 2 episodes toay dry cough rinning nose 3 days body acke weakness 2 days								
oe chest clear abdomkinal discomfort vitals are stable								
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 : 124 T : 36.5 HR : 62 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM					
Type	Code	Diagnosis			
Primary	R11.10	Vomiting, unspecified			
Secondary	J30.9	Allergic rhinitis, unspecified			
Secondary	J06.9	Acute upper respiratory infection, unspecified			
Secondary	E86.0	Dehydration			

Type	Code	Diagnosis
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
9	GP Consultation	General Consultation	25.0000
0002-100101-1001	Sodium Chloride & Dextrose (Dextrose/Sodium Chloride [0.18% W/V 4.3% W/V]) Solution For Infusion (500ml, Plastic Bottle)	Pharmacy	4.5000
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000
86140	C-reactive protein;	Lab	15.0000
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Lab	20.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
0005-150403-1021	PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION	Pharmacy	0.9000
0005-107704-0802	TRIAZONE I.V.-(CEFTRIAZONE : 1 G) POWDER FOR INJECTION	Pharmacy	58.5000

Code	Generic	Duration	Instructions
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
0097-393801-2471	(AMMONIUM CHLORIDE : 131.5 MG/5 ML) (DIPHENHYDRAMINE HCL : 13.5 MG/5ML) SYRUP (ALCOHOL FREE)	7	Take 2Tablets 3 Time(s) per Day For 7 Day(s) others
0252-150407-1171	(METOCLOPRAMIDE : 10 MG) TABLETS	3	Take 1Tablets 3 Time(s) per Day For 3 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	7	Take 1Tablets 1 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	
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Is In-patient Required ? Length of Stay	Indicate Provider	Estimate Cost
<i>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>		
<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 : Humaira		
Tel / Fax (important):		
 		
 		
Patient's Signature(Parent if minor)		
Date :	Date : 23-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.