

eASOAP FORM


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

Patent Name:	WARDA SHAFIK TAWFIK IBRAHIM	Gender:	Female	Validity Between:	20/02/2024 and 19/02/2025
Card No:	9240-80CD-9BDC-75E9	DOB:	2/1/1993 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1993-8618895-9	Service Date:	25-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0565410545		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	40869	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
co breast pain pus from brest 14 days								
history of brest feed oe								
vitals are stable inflamed and hot left breast pus is coming								
Past Medical Surgical History?						Date of Symptoms/illness started		
				☐ Yes	☐ No	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 : T : HR : RR :			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	N61.1	Abscess of the breast and nipple					
Secondary	N64.4	Mastodynia					
Secondary	R52	Pain, unspecified					

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

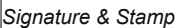
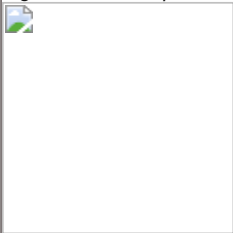
Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illness occur:
☐ Yes ☐ No	☐ Yes ☐ No	
Date of accident or beginning of illness:		

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

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000
9	GP Consultation	General Consultation	25.0000
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	Lab	25.0000
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0195-107704-0802	CEFTRIAXONE-TABUK IM	Pharmacy	48.5000
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

Code	Generic	Duration	Instructions
0219-533801-0392	(ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) others
0724-107002-1171	(CAFFEINE : 60 MG) (PARACETAMOL : 500 MG) TABLETS	7	Take 1Tablets 2 Time(s) per Day For 7 Day(s) others
0248-187801-1171	(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	7	Take 1Tablets 3 Time(s) per Day For 7 Day(s) others
0139-116206-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS	7	Take 1Tablets 2 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>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 : Humaira		
Tel / Fax (important):		
  		
Date :		
Date : 25-Apr-2024		
Note: Claims must be submitted along with supporting documents within 30 days from date of service		

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