

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	AMMAR WAJID	Gender:	Male	Validity Between:	21/02/2024 and 20/02/2025
Card No:	0EEF-1E70-4575-6F8A	DOB:	2/9/1989 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1989-1009979-9	Service Date:	28-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	+971 58 522 1033		
		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42934	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 PUSY BLISTER ON THE GROIN 3 DAYS								
OE PUS IS OZZING 3 LARGE BLISTER CHEST IS CLEAR VITALS								
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 : 132		T : 36.5		HR : 132		RR : 22	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM											
Type	Code	Diagnosis									
Primary	L02.91	Cutaneous abscess, unspecified									
Secondary	R21	Rash and other nonspecific skin eruption									
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:		

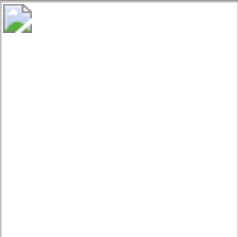
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
9	GP Consultation	General Consultation	25.0000
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
0005-149902-1021	CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION FOR INJECTION	Pharmacy	6.5000
0195-107704-0802	CEFTRIAXONE-TABUK IM-(CEFTRIAXONE : 1 G) POWDER FOR INJECTION	Pharmacy	48.5000

Code	Generic	Duration	Instructions
1195-678401-1171	(CALCIUM : 400 MG) (MAGNESIUM : 150 MG) (VITAMIN D (AS D3) : 2.5 MCG) (ZINC : 5 MG) TABLETS	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)
0281-128401-0651	(FUSIDIC ACID : 2%) OINTMENT	1	Take 1Cream 3 Time(s) per Day For 1 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
4417-711202-0391	(IBUPROFEN (AS L-ARGININE SALT) : 400 MG) FILM COATED 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):		

  <i>Signature & Stamp</i>	 <i>Patient's Signature(Parent if minor)</i>
Date :	Date : 28-Apr-2024
Note: Claims must be submitted along with supporting documents within 30 days from date of service	

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