

eASOAP FORM



ADMINISTRATIVE

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

Patent Name:	HIRANYA PATEL	Gender:	Female	Validity Between:	09/10/2023 and 08/10/2024
Card No:	AA85-CE93-1420-4AC0	DOB:	10/11/2012 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natnol ID:	784-2012-2198645-4	Service Date:	29-Apr-2024	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0545453771		
Payer Name:	ORIENT INSURANCE P.J.S.C	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	43011	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

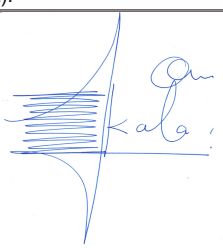
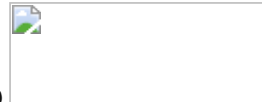
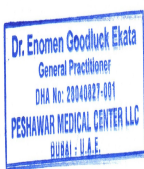
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
C/o: Pain on the right kneel joint since the past 2 weeks.								
Said to have began after playing Rugby sport intensely.								
Otherwise, there is no other history of trauma.								
There is no fever and no urinary symptom								
she also does not have any other medical condition of note.								
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 : 0 T : 37.3 HR : 92 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	M08.961	Juvenile arthritis, unspecified, right knee					
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		
9	GP Consultation	General Consultation	25.0000		
86060	Antistreptolysin O; titer	Lab	25.0000		
80076	Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)	Lab	85.0000		
86038	Antinuclear antibodies (ANA);	Lab	25.0000		
86431	Rheumatoid factor; quantitative	Lab	20.0000		
85652	Sedimentation rate, erythrocyte; automated	Lab	8.0000		
86140	C-reactive protein;	Lab	15.0000		
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		
0426-160701-2541	(METHYL SALICYLATE : N/A) (HYDROXYETHYL SALICYLATE : N/A) (ETHYL SALICYLATE : N/A) (METHYL NICOTINATE : N/A) TOPICAL AEROSOL SPRAY	7	Take 1Spray 3 Time(s) per Day For 7 Day(s) others		
☐ Pharmacy:		Estimated Costs		☐ Laboratory / Radiology:	
Is the following required		☐ Surgery:		☐ Endoscopy:	
		☐ Physiotherapy:		☐ Other Procedures:	
				If yes please specify	
Is In-patient Required ? Length of Stay					
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.		Indicate Provider		Estimate Cost	
Treating Physician Name : Enomen Goodluck		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.			
Tel / Fax (important):					
 Signature & Stamp		 Patient's Signature(Parent if minor)			
		Date : 29-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.