eASOAP FORM

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

Patent Name:	**PEDRO JAVIER RIVERA RIVERA**	Gender:	**Male**	Validity Between:	**17/04/2024 and 16/04/2025**
Card No:	**43AD-4B86-2DC9-7E18**	DOB:	**4/18/1976 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1976-9740390-1**	Service Date:	**29-Apr-2024**	Radiology:	**Covered**
		Patent's Tel No:	**0503224688**		
Policy Holder:		Threshold Limit:			
Payer Name:	**TAKAFUL EMARAT**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**43016**	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**		
	DD	MM	YYYY
Complaint Recurrent headaches for the past 2 weeks. There is associated dizziness and weakness. He is not a known hypertensive and not diabetic. BP at presentation however noted to be elevated. There is no sudden sweatiness nor hot flushes and has no previous history of similar condition nor pheachromocytoma in the past.			

Past Medical Surgical History?	○ Yes	○ No	**Date of Symptoms/illness started**		
			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 : 146 T : 35.6 HR : 78 RR : 22

Assessment/Diagnosis : ○ **Acute** ○ **Chronic** ○ **Confirmed** ○ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	J02.9	Acute pharyngitis, unspecified
Secondary	I10	Essential (primary) hypertension
Secondary	E78.5	Hyperlipidemia, unspecified
Secondary	R42	Dizziness and giddiness
Secondary	R51.9	Headache, unspecified

Type	Code	Diagnosis
Secondary	Z83.3	Family history of diabetes mellitus

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
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Co.Pay	10.0000
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy	2.3400
0005-149902-1021	CLOFEN	Pharmacy	6.5000
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Co.Pay	10.0000
82947	Glucose; quantitative, blood (except reagent strip)	Lab	12.0000
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)	Lab	45.0000
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
0252-389902-1172	(LORATADINE : 5 MG) (PSEUDOEPHEDRINE SULPHATE : 120 MG) TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) evening
0005-107001-0051	(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	5	Take 2Tablets 2 Time(s) per Day For 5 Day(s) after meal
0027-142201-0831	(DICLOFENAC POTASSIUM : 50 MG) POWDER FOR SOLUTION	10	Take 1sachet 3 Time(s) per Day For 10 Day(s) after meal

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated 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 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 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 benefts. Medical management is the sole responsibility of doctor and the patent.*	
Treating Physician Name : **Enomen Goodluck**		
Tel / Fax (important):		

Signature & Stamp Dr. Enomen Goodluck Ekata General Practitioner DHA No: 20040827-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 29-Apr-2024
Note: Claims must be submited along with supportng documents within 30 days from date of service	

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