

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	AHMED NABIL	Gender:	Male	Validity Between:	15/01/2024 and 14/01/2025
Card No:	0748-83AB-CBF3-CC06	DOB:	8/6/1988 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-0949495-2	Service Date:	30-Apr-2024	Radiology:	Covered
		Patent's Tel No:	0567994771		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	42866	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
Pain in throat, blocked nostrils and nasal congestion.							
Not a known hypetrensive and not a known diabetic.							
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)

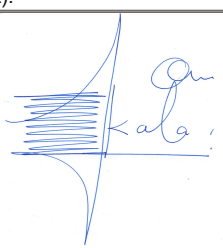
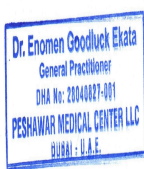
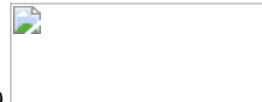
Clinical Findings :		Vital Signs : B/P : 110 T : 36.9 HR : 72 RR : 20	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	J01.40	Acute pansinusitis, unspecified	
Secondary	J03.90	Acute tonsillitis, unspecified	
Secondary	R50.9	Fever, 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

Code	Generic	Duration	Instructions
5253-649501-3851	(MOMETASONE FUROATE (AS MONOHYDRATE) : 50 MCG/DOSE) NASAL SPRAY	7	Take 1Spray 2 Time(s) per Day For 7 Day(s) after meal
0005-116801-1162	(SODIUM CITRATE : 57 MG/5ML) (AMMONIUM CHLORIDE : 131.5 MG/5 ML) (MENTHOL : 1.1 MG/5 ML) (DIPHENHYDRAMINE : 13.5 MG/5ML) SYRUP	7	Take 10ML 3 Time(s) per Day For 7 Day(s) after meal
0139-116207-1171	(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 Day(s) after meal
0005-119803-1171	(PREDNISOLONE : 20 MG) TABLETS	7	Take 1Tablets 1 Time(s) per Day For 7 Day(s) after meal
1516-107902-1171	(IBUPROFEN : 400 MG) TABLETS	12	Take 1Tablets 2 Time(s) per Day For 12 Day(s) after meal
0195-123701-0391	(CETIRIZINE HCL : 10 MG) FILM COATED TABLETS	10	Take 1Tablets 1 Time(s) per Day For 10 Day(s) after meal
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2Time(s) perDay For 10 Day(s) after meal

☐ 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 : Enomen Goodluck		
Tel / Fax (important):		
Signature & Stamp   Patient's Signature(Parent if minor) 		
Date :		
Date : 30-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.