

eASOAP FORM



ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **Irham Medical Center Arjan**

Patent Name:	PIYATHIDA SOMBOOT	Gender:	Female	Validity Between:	07/04/2023 and 06/04/2024
Card No:	105B-4CA6-7C82-AB2F	DOB:	3/22/1988 12:00:00 AM	Coverage Information for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1988-9715314-8	Service Date:	15-Apr-2023	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0558368597		
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	39907	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

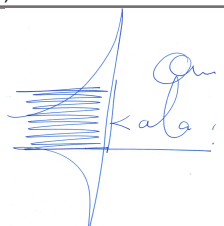
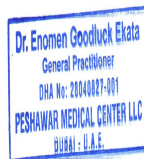
SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
C/o: Sore throat, headache and runny nose.								
No fever but has generalized body pain.								
Took panadol last night.								
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 : 120 T : 36.5 HR : 82 RR : 22			
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected							
INDICATE DIAGNOSIS NOT SYMPTOM							
Type	Code	Diagnosis					
Primary	J06.9	Acute upper respiratory infection, unspecified					
Secondary	R07.0	Pain in throat					
Secondary	R05	Cough					
Secondary	R50.9	Fever, unspecified					
Secondary	E11.9	Type 2 diabetes mellitus without complications					
Secondary	R51	Headache					

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?	
☐ Yes ☐ No		☐ Yes ☐ No	
Date of accident or beginning of illness:			
Describe how the accident or work related injury/illness occur:			
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim			
CPT Code	Treatment	Type	Price
96374	IV PUSH	Co.Pay	10.0000
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	General Consultation	8.4000
82948	Glucose; blood, reagent strip	Lab	10.0000
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
9	CONSULTATION GP	General Consultation	25.0000
Code	Generic	Duration	Instructions
0097-127402-0391	(AZITHROMYCIN : 250 MG) FILM COATED TABLETS	5	Take 1Tablets 1Time(s) perDay For 5 Day(s) after meal
0070-148701-1171	(LORATADINE : 10 MG) TABLETS	10	Take 1Tablets 1Time(s) perDay For 10 Day(s) others
0696-107902-0392	(IBUPROFEN : 400 MG) FILM COATED TABLETS	3	Take 1Tablets 2Time(s) perDay For 3 Day(s) after meal
0005-114501-2481	(AMBROXOL : 15 MG/5ML) SYRUP (SUGAR FREE)	10	Take 5ML 2 Time(s) per Day For 10 Day(s) others
0252-185801-0391	(DIPHENHYDRAMINE : 25 MG) (PARACETAMOL : 500 MG) (PSEUDOEPHEDRINE : 30 MG) FILM COATED TABLETS	10	Take 1Tablets 2 Time(s) per Day For 10 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 : Enomen Goodluck		
Tel / Fax (important):		
 Signature & Stamp  Piyathida Patient's Signature(Parent if minor)		
Date :		
Date : 15-Apr-2023		

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 effects caused due to the claims submissions. NEXtCare assumes no

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