eASOAP FORM

R50.9

Secondary



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

Patent Name:	MALIK MUHA ASHRAF WA UBAID ULLA	RRAICH	Gender:	Mai	le	,	Validity Between:	;	29/03/2	023 and 28	3/03/2024	
Card No:	43DD-6B18-3939-D876 DOB:			3/8/1980 12:00:00 AM		Coverage Informat for:	on	Out Patient				
Pin #:			Identty Car	d:		1	Network:		RN UAI MEDGI	E (Al Ansaı ULF	ri-AUH)-	
Natonal ID:	784-1980-827	9825-1	Service Dat	e: 22-	Sep-2023	1	Radiology:	(Covere	d		
			Patent's Te	No: 052	29664671							
Policy Holder:			Threshold Limit:									
Payer Name:	ORIENT INSU P.J.S.C	JRANCE	Class:	Noi	rmal							
			Out-Patent	:								
Category:	Category B		Patent's Fil No:	e 348	336	ı	Pharmacy:	(Co-Par	t: 20%		
Gatekeeper:	No		Consultato	n:		İ	_aboratory:	(Covere	d		
Referral No: Referred Service:												
SUBJECTIVE ASS	SESSMENT											
Symptom(s) as	described by th	ne patent (Ch	nief Complain	t):					Date of Symptoms/illness started			
Complaint	, .								DD	MM	YYYY	
today.	grade fever (38					severe ep	igastric pain since					
								Date of Symptoms/illness started				
Past Medical Su	urgical History?			○ Yes			O No		DD D	MM	YYYY	
									Date of	Symptom	s/illness started	
Obs/Gyn Claims	S								DD	MM	YYYY	
Para	Gravida:	□ АВ:	LMP:	Marital	Status:		Marital Date:					
What date did the	e Patient first fee	l el same / simil	l lar Symptom(s	 s) : dd mr	m yyyy		L					
-				•		hat Asses	ssment and since v	vhen:				
OBJECTIVE / AS												
Clinical Finding		<u> </u>		,	Vita	al Signs :	B/P : 110	T : 39		HR:	100 RR	
Assessment/Dia	agnosis :	Acute	○ Chronic	O Co	nfirmed	OSusp	ected					
Туре		Code		Diagnosis								
Primary		K29.00		Acute gastritis without bleeding								
Secondary		J00		Acute nasopharyngitis [common cold]								

Fever, unspecified

0391 (CETIRIZINE HCL: 10 MG) FILM COATED TABLETS 10 10 Day(s) after meal 10 10 Day(s) after meal 11 10 Day(s) after meal 11 10 Day(s) after meal 12 10 Day(s) after meal 13 Take 10ML 2 Time(s) per Day(s) after meal 14 10 Day(s) after meal 15 Day(s) after meal 16 Day(s) after meal 17 Take 10ML 2 Time(s) per Day(s) after meal 18 10 Day(s) after meal 19 Take 1Tablets 1 Time(s) per Day(s) after meal 10 Day(s) after meal 10 Take 1Tablets 2 Time(s) per Day(s) after meal 10 Day(s) after meal 1	Diagnosis								
R05 Cough									
Accident or illness due to work? Injury due to road accident or work related liness/injury Accident or illness due to work? Injury due to road accident or work related injury/illness occident? Describe how the accident or work related injury/illness occident? Over S No									
Accident or illness due to work? Injury due to road accident? Yes No	Cough								
Accident or illness due to work? Oves No Oves No Oves									
Active of accident or beginning of illness: MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Tope ODEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR Pharmacy DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR Pharmacy O195-107704- O2015-107704-	the accident or work related injury/illness occur:								
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim Type 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour Co.Pay 9005-149902- 1021 CLOFEN Pharmacy 1025-122107- 1022 Pharmacy 1015-122107- 1022 Pharmacy 1015-122107- 1022 Pharmacy 1016-107704- 10801 CEFRIAXONE-TABUK IV Pharmacy 86140 C-reactive Protein Lab 85025 Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count 9 GP Consultation General Consultation Code General Consultation CCGENIZINE HCL: 10 MG) FILM COATED TABLETS 10 Take 17ablets 1 Time(s) per 10 Day(s) after meal 1002-169701- 10161 (AMMONIUM CHLORIDE: N/A) (DIPHENHYDRAMINE: N/A) SYRUP 7 Day(s) after meal 10097-127405- 10391 (AZITHROMYCIN: 500 MG) FILM COATED TABLETS 3 Take 17ablets 1 Time(s) per 10391 (PSE-127405- 10391 (PSE-1000FPHEDRINE: 30 MG) FILM COATED TABLETS 3 Take 17ablets 2 Time(s) per 10392 (PSE-18801-) (IBURPOFEN: 150 MG) (PARACETAMOL: 500 MG) 10 Day(s) after meal 1003-127405- (IBURPOFEN: 150 MG) (PARACETAMOL: 500 MG) FILM COATED TABLETS 10 Day(s) after meal 1003-127405- (IBURPOFEN: 150 MG) (PARACETAMOL: 500 MG) FILM COATED TABLETS 10 Day(s) after meal 10 Day(s) after									
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O391 (AZTHROMYCIN: 500 MG) FILM COATED TABLETS 3 3 Day(s) after meal 0252-185801- (DIPHENHYDRAMINE: 25 MG) (PARACETAMOL: 500 MG) 10 Take 1Tablets 2 Time(s) per 10 Day(s) after meal 10 Day(Take 10ML 2 Time(s) per Day For 7 Day(s) after meal								
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OB92 TABLETS Estmated Costs Laboratory / Radiology: Estmated Costs Surgery: Other Procedures: If yes please specify Indicate Provider Indicate Provider Estimated Costs Indicate Provider Indicate Provider Indicate Provider Estimated Costs Indicate Provider Insurer, Employer or other Organ yellow and history to NEX the purpose of determining insurance benefts. Medical management is the responsibility of doctor and the patent. Indicate Provider Insurer, Employer or other Organ yellow and history to NEX the purpose of determining insurance benefts. Medical management is the responsibility of doctor and the patent.	Take 1Tablets 2 Time(s) per Day For								
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Sthe following required Physiotherapy: Other Procedures: If yes please specify Indicate Provider Indicate Provider Estimate I hereby certfy that all information mentoned are correct at the medical services shown on this form were medically indicated & necessary for the management of this case. Indicate Provider I hereby authorize any Healthcare Provider, Insurer, Employer or other Organically information regarding my medical condition and history to NEX the purpose of determining insurance benefits. Medical management is the responsibility of doctor and the patent. Treating Physician Name: Enomen Goodluck	1								
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his case. responsibility of doctor and the patent. Treating Physician Name : Enomen Goodluck	-								
Fel / Fax (important):									

Signature & Stamp					
	Patient's Signature(Parent if minor)				
Date :	Date : 22-Sep-2023				
Note: Claims must be submited along with supportng 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 final opinion will be given by the NEXtCARE claims doctors.