eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out-Patient** at the **Peshawar Medical Centre**

Patient Name:	**Abel Simon Ighem**	Gender:	**Male**	Validity Between:	**21/Jul/2025and20/Jul/2026**
Card No:	**6551D847F77E2A91**	DOB:	**07/May/1991**	Coverage Information for:	**Out-Patient**
Pin #:	**P/01/1313/2025/4624**	Identity Card	**784-1991-1804439-7**	Network:	**OIC-RN3 OP @ Clinics Only**
National ID:	**784-1991-1804439-7**	Service Date:	**24-Aug-2025 05:50:05 PM**	Radiology:	**Covered**
Regulator Member ID:	**I008-002-123113541-01**	Patient's Tel No:	**971971562093**		
Policy Holder:	**Abel Simon**	Threshold Limit:			
Payer Name:	**INS008 - Orient Insurance PJSC**	Class:	**B**		
		Out-Patient :			
		Patient's File No:		Pharmacy:	
Gatekeeper:	**No**	Consultation : **Covered**			
				Laboratory:	**Covered**

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):	**Date of Symptoms/illness started** DD MM YYYY

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:	

OBJECTIVE ASSESSMENT

Clinical Findings:		**Vital Signs:**	B/P		T		HR		RR	

Assessment / Diagnosis:	☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected
	Indicate diagnosis not symptom
1.	
2.	

ACCIDENT/OCCUPATIONAL Claim Information (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:	DD MM YYYY	

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions/Reports/Results must be enclosed to consider the claim

☐ 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 _____ days	Indicate Provider:	Estimated Cost:

I hereby certify that all information mentioned 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 Organization to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility

Treating Physician Name:			
Tel / Fax (important):	Date: DD / MM / YYYY		
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: DD MM YYYY

Note: Claims must be submitted along with supporting documents within 30 days from date of service