EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	MUHAMMAD YOUSAF SHAHZ	Gender:	Male	Validity Between:	07/Feb/2022and06/Feb/2023
Card No:	F257853314EC4B9E	DOB:	24/May/2016	Coverage Information for:	Out-Patient
Pin #:	P/01/1305/2022/3957	Identity Card	784-2016-5828365-6	Network:	OIC-OP @ PCP & Sp Referral @ RN
National ID:	784-2016-5828365-6	Service Date:	01-Jun-2022 12:18:56 PM	Radiology:	Co-Part: 20%
		Patient's Tel No:	971558282762		
Policy Holder:	MUHAMMAD YOUSAF.SHAHZAD.	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	WARD		
		Out-Patient :	Covered		
		Patient's File No:		Pharmacy:	Co-Part: 30%
Gatekeeper:	No	Consultation :	Co-Part: 20%		
				Laboratory:	Co-Part: 20%

J03.90

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint):	Date of Symptoms/illness started
c/o fever, pain in throat - pus	DD MM YYYY
Past Medical Surgical History? ☐ YES ☐ NO fever on off 2wks.	Date of Symptoms/illness started DD MM YYYY
Obs/Gyn Claims	Date of Symptoms/illness started
Para: ☐ Gravida: ☐ AB: ☐ LMP: Marital Status: Marital Date:	DD MM YYYY

OBJECTIVE ASSESSMENT

Clinical Findings:	Vital Signs:	B/P	-	T	36.6	HR	116	RR	22

Assessment / Diagnosis: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected

Indicate diagnosis not symptom

1. J03.1, R07.0, R10.9, R11.0, D50.9, B95.4
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
		CBC	

Is the following required	☐ Surgery:	☐ Endoscopy:	Absolute
	☐ 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 of doctor and the patient.

Dr. Rubna Jaseem
General Practitioner
DHA No: 77233809-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Treating Physician Name:			
Tel / Fax (important):	Date:		
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 01 06 22

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