EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	May Khant Nyar Thwin ,	Gender:	Male	Validity Between:	24/Aug/2021and19/Aug/2022
Card No:	E57ACEE91DD7C902	DOB:	14/Dec/1995	Coverage Information for:	Out-Patient
Pin #:		Identity Card	111-1111-1111111-1	Network:	NT-OP @PCP&SpRef@RN3 Ex.AGC
National ID:	111-1111-1111111-1	Service Date:	05-Jun-2022 08:16:16 PM	Radiology:	Co-Part: 10%
Regulator Member ID:	I018-002-117108473-01	Patient's Tel No:	971551464101		
Policy Holder:	PULLMAN JUMEIRAH LAKES TOWERS HOTEL	Threshold Limit:			
Payer Name:	INS018 - Noor Takaful DMCC Family PJSC	Class:	WARD		
		Out-Patient : Covered			
Category:	CAT D	Patient's File No:		Pharmacy:	Co-Part: 10%
Gatekeeper:	No	Consultation : Co-Part: 10% Max(25 AED)			
				Laboratory:	Co-Part: 10%

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): Abdominal pain
Dermatitis

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

Para: ☐ Gravida: ☐ AB: ☐ LMP: Marital Status: Marital Date:

Date of Symptoms/illness started: DD MM YYYY

OBJECTIVE ASSESSMENT

Clinical Findings:

Vital Signs: B/P 130/90 T 37°C HR 116b/mt RR 20b/mt

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

Indicate diagnosis not symptom

1. Encounter for issue of med. certificate Z02.79
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:

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

I hereby certify that all information mentioned above is true & that the medical services shown on this form are 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.

Treating Physician Name:			
Tel / Fax (important):	Date: 05-06-22		
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 05 06 22

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