EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	MINHAJ ASGAR EJAZUL HAQ	Gender:	Male	Validity Between:	02/Aug/2021and18/Jun/2022
Card No:	B1299EEAF796EDB5	DOB:	24/Dec/1995	Coverage Information for:	Out-Patient
Pin #:	24094389	Passport	P2502670	Network:	OIC-RN2 UAE Only
National ID:	784-1995-6531720-5	Service Date:	07-Jun-2022 05:59:12 PM	Radiology:	Covered
Regulator Member ID:	I008-002-117061247-01	Patient's Tel No:	971553698015		
Policy Holder:	ADCI GLOBAL INVESTMENTS LLC	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	A		
Category:	CAT B-NJ	Out-Patient :			
Gatekeeper:	No	Patient's File No:		Pharmacy:	Covered 28
		Consultation : Co-Part: 20% Max(50 AED)		Laboratory:	Covered

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): Fever Cold Hepatomegaly DAP 5d's Hurt — Date of Symptoms/illness started: DD MM YYYY

Past Medical Surgical History? ☐ YES ☑ NO — Date of Symptoms/illness started: DD MM YYYY

Mom - 30's No Hyp No Alcohol

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 130/80 | T 37C | HR 96 bpm | RR 20 bpm

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
Azithromycin 250mg OD x 6 days			

Is the following required			
	☐ Surgery:	☐ Endoscopy:	TSH CBC CMP ECG GGT LSA
	☐ 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

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

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:			Minhaj Asgar
Tel / Fax (important):	Date: DD MM YYYY		
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 07 06 22 YY

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