EASOAP FORM

NEXtCARE
Your Health Managed with Care

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

Patient Name:	MAJHARUL ISLAM YONUS MI	Gender:	Male	Validity Between:	17/Oct/2021and18/Jun/2022
Card No:	D27C42C3053F948E	DOB:	17/Mar/1997	Coverage Information for:	Out-Patient
Pin #:	24518886	Passport	A00189915	Network:	OIC-RN2 UAE Only
National ID:	111-1111-1111111-1	Service Date:	07-Jun-2022 06:03:48 PM	Radiology:	Covered
Regulator Member ID:	I008-002-117262855-01	Patient's Tel No:	971544695922		
Policy Holder:	ADCI GLOBAL	Threshold Limit:			
Payer Name:	INVESTMENTS LLC INS008 - Orient Insurance PJSC	Class:	A		
		Out-Patient :			
Category:	CAT B1-NJ	Patient's File No:		Pharmacy:	Covered
Gatekeeper:	No	Consultation : **Co-Part: 20% Max(50 AED)**		Laboratory:	Covered

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Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): FEVER Sore Throat Cough X5 DAYS COLD FATIGUE — Date of Symptoms/illness started: DD MM YYYY

Past Medical Surgical History? ☐ YES ☐ NO — No Cig No Alcohol — 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 130/80 T 37.7C HR 92bpm RR 18bpm

Assessment / Diagnosis: URTI Sore Throat Fever — ☐ 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
- Amoxil 500mg TID x 7 Days		CBC	
- Zyrtec 10mg OD x 7 days		CMP Electrolytes	

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 actually rendered & necessary for the management of this case.

Dr. Sajid Samiullah 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:			
Tel / Fax (important):		*Date:* DD / MM / YYYY	
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 07 06 22

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