EASOAP FORM

NEXtCARE
Your Health Managed with Care

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

Patient Name:	**SHAHZEEL KHAN ABDUL SALA**	Gender:	**Male**	Validity Between:	**30/Nov/2021and29/Nov/2022**
Card No:	**006BC9A28C40831E**	DOB:	**01/Jan/1992**	Coverage Information for:	**Out-Patient**
Pin #:	**P/30/1306/2021/338**	Identity Card	**784-1992-5098753-6**	Network:	**OIC-OP @ PCP & Sp Referral @ RN**
National ID:	**784-1992-5098753-6**	Service Date:	**10-Jun-2022 12:08:24 PM**	Radiology:	**Co-Part: 20%**
Policy Holder:	**SHAHZEEL KHAN.ABDUL SALAM.**	Patient's Tel No:	**971502265377**		
		Threshold Limit:			
Payer Name:	**INS008 - Orient Insurance PJSC**	Class:	**WARD**		
		Out-Patient :			
		Patient's File No:			
Gatekeeper:	**No**	Consultation : **Co-Part: 20%**		Pharmacy:	**Co-Part: 30%**
				Laboratory:	**Co-Part: 20%**

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

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

infertility

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 117/79mmHg T 36.9°C HR 78 RR 20

Wt 69.1, Ht 169 cm SpO2 98%.

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? ☐ YES ☐ NO

Injury due to road accident? ☐ YES ☐ NO

Describe how the accident or work related injury/illness occur:

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.

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

Treating Physician Name:

Tel / Fax (important): Date: 10-06-22

Signature & Stamp

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.

Patient's Signature (parent if minor) Date: 10 06 2021

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