ASOAP 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:	15-Jun-2022 07:37:23 PM	Radiology:	Co-Part: 20%
		Patient's Tel No:	971502265377		
Policy Holder:	SHAHZEEL KHAN.ABDUL SALAM.	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	WARD		
		Out-Patient :			
		Patient's File No:		Pharmacy:	Co-Part: 30%
Gatekeeper:	No	Consultation : Co-Part: 20%			
				Laboratory:	Co-Part: 20%

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): 26 Yrs. G6 P2+A3. c/o Pregnancy. 27 wks and 4 days.

Date of Symptoms/illness started: DD MM YYYY

Past Medical Surgical History? ☐ YES ☐ NO

4/12/21 Married

Date of Symptoms/illness started: DD MM YYYY

Obs/Gyn Claims					
Para: 2 ☐	Gravida: 6 ☐	AB: 3 ☐	LMP:	Marital Status:	Marital Date:

Date of Symptoms/illness started: DD MM YYYY

OBJECTIVE ASSESSMENT

Clinical Findings:

Vital Signs: B/P | T | HR | RR

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

Indicate diagnosis not symptom

1. Pregnancy 27 weeks
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	Consultation.
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
		① Preg. hsG 2nd trimester. ② CBC, RBS, Urine-R, Blood grp, +/-, HbsAg, HCV Ab, TSH, VDRL, Rubella IgG.	

Is the following required	☐ Surgery:	☐ Endoscopy:
	☐ Physiotherapy:	☐ Other Procedures: HIV I+II
		If yes please specify

Is In-patient Required? Length of stay _____ days | Indicate Provider: | Estimated Cost: 19K

I hereby certify that all information mentioned are correct & that the medical services shown on this list were medically indicated & necessary for the management of this case.

Dr. Rekha Mathur
Specialist Obstetrics and Gynecology
DHA No: 00167982-003
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	15/6/22	*Patient's Signature (parent if minor)*	Date: DD MM YYYY

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