EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	**Bianka Actub Manihayme**	Gender:	**Female**	Validity Between:	**04/Nov/2021and21/Sep/2022**
Card No:	**F4AAE048E0FF34ED**	DOB:	**27/Jun/1994**	Coverage Information for:	**Out-Patient**
Pin #:	**24634918**	Passport	**P7534404A**	Network:	**OIC-OP@PCP & SpRef@RN3+4Hos**
National ID:	**784-1994-1090485-0**	Service Date:	**10-Jun-2022 02:12:45 PM**	Radiology:	**Co-Part: 10%**
Regulator Member ID:	**I008-002-117314462-01**	Patient's Tel No:	**971500000000**		
Policy Holder:	**ULTRA BRASSERIE**	Threshold Limit:			
Payer Name:	**RESTAURANT (BRANCH) INS008 - Orient Insurance PJSC**	Class:	**B**		
		Out-Patient :			
Category:	**CAT A**	Patient's File No:		Pharmacy:	**Co-Part: 10%**
Gatekeeper:	**No**	Consultation : **Co-Part: 10% Max(40 AED)**		Laboratory:	**Co-Part: 10%**

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): — Date of Symptoms/illness started: DD MM YYYY

Cough Sore throat X 1 Headache
RUNNY Nose + Sick Contact

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

At Clog – 3/DAY At Alcohol 3-5 DRINKS
1 MONTH

Fatigue

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 100/70 | T 37°C | HR 78b/m | RR 18b/m
Height-164(m), weight-62kg

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
		CBC, Electrolytes	
		TSH, Lipid profile	

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. Salid Sanaullah Khan
General Practitioner
DHA No: 0375022-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

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.

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: 10 06 2022

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