EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	ALI EZAT MOHAMED ELATTAR	Gender:	Male	Validity Between:	15/Mar/2022and14/Mar/2023
Card No:	5A484EC56DBBB763	DOB:	31/Jan/1988	Coverage Information for:	Out-Patient
Pin #:		Identity Card	784-1988-8624281-1	Network:	RN3 (OP @ Hospitals & Clinics) (S)
National ID:	784-1988-8624281-1	Service Date:	10-Jun-2022 08:49:15 PM	Radiology:	Co-Part: 10%
Regulator Member ID:	I040-002-114132059-01	Patient's Tel No:	971551080986		
Policy Holder:	BIZRAHMED CENTERS L.L.C (CAT B)	Threshold Limit:			
Payer Name:	INS040 - Union Insurance Company P.J.S.C.	Class:	Ward		34
		Out-Patient :			
Category:	CATEGORY B	Patient's File No:		Pharmacy:	Co-Part: 10%
Gatekeeper:	No	Consultation : Co-Part: 10% Max(25 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

ACNE FACE RASH - 1 MONTH NO CIGG NO ALCOHOL

Past Medical Surgical History? ☐ YES ☐ NO — Date of Symptoms/illness started

Obs/Gyn Claims — Date of Symptoms/illness started

Para: ☐	Gravida: ☐	AB: ☐	LMP:	Marital Status:	Marital Date:

OBJECTIVE ASSESSMENT

Clinical Findings:

Vital Signs: B/P 130/80 T 36.6C HR 60bpm RR 18b/mt

Assessment / Diagnosis: ACNE Vulgaris ☐ 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

Is the following required			
	☐ Surgery:	☐ Endoscopy:	CBC Electrolytes ISH, Lipid Profile
	☐ Physiotherapy:	☐ Other Procedures:	
		If yes please specify	

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

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No. 0575224-001
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:	11	06	22

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