ASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	MAHIN DHABE	Gender:	Male	Validity Between:	27/Jul/2021and26/Jul/2022
Card No:	DCA6AE869CE83757	DOB:	10/Nov/2017	Coverage Information for:	Out-Patient
Pin #:	P/01/1305/2021/21296	Identity Card	784-2017-6904716-4	Network:	OIC-OP @ PCP & Sp Referral @ RN
National ID:	784-2017-6904716-4	Service Date:	10-Jun-2022 08:48:49 PM	Radiology:	Co-Part: 20%
		Patient's Tel No:	971504727165		
Policy Holder:	MAHINSAGARDHABE.	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	WARD		4.540
		Out-Patient : Covered			
		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):	Date of Symptoms/illness started
Urine analysis	DD MM YYYY
Past Medical Surgical History? ☐ YES ☐ NO	Date of Symptoms/illness started DD MM YYYY
Obs/Gyn Claims	Date of Symptoms/illness started
Para: ☐ Gravida: ☐ AB: ☐ LMP: Marital Status: Marital Date:	DD MM YYYY

OBJECTIVE ASSESSMENT

Clinical Findings:

Vital Signs: B/P T 37/C HR 120/min RR 18/min

Assessment / Diagnosis: R82.99 S00.31XA ☐ 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
		87086, 81001, 82043	

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.

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:		
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