~~ASOAP FORM~~

NEXTCARE
Your Health Managed with Care

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

Patient Name:	Adis Fatic	Gender:	Male	Validity Between:	14/Feb/2022and13/Feb/2023
Card No:	FA605A58A52DB18D	DOB:	08/Apr/1984	Coverage Information for:	Out-Patient
Pin #:		Passport	B2849196	Network:	OIC-OP @ PCP & Sp Referral @ RN
National ID:	784-1984-3198362-0	Service Date:	13-Jun-2022 07:59:42 PM	Radiology:	Co-Part: 20%
Regulator Member ID:	I008-002-117649424-01	Patient's Tel No:	971561600714		
Policy Holder:	HOME HANDLE	Threshold Limit:			
Payer Name:	TECHNICAL SERVICES-DHA INS008 - Orient Insurance PJSC	Class:	B		
		Out-Patient :			
Category:	Category2	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): CP Neck pain Smoke 2 PPD 10 YRS Alcohol 2-3 Beers/wk

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: Smoker lung

Vital Signs: B/P 130/75 T 37c HR 86 RR 18bl/mt

MISSED BEAT - Allythmies

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. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
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:		FATIC ADIS	
Tel / Fax (important):	Date: DD / MM / YYYY		
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 13 06 22

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