NEXTCARE
Your Health Managed with Care

EASOAP FORM

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

Patient Name:	LITTO .	Gender:	Male	Validity Between:	04/Aug/2021and03/Aug/2022
Card No:	DF0FCAFA1D224684	DOB:	30/May/1988	Coverage Information for:	Out-Patient
Pin #:	P030	Passport	P0465590	Network:	OP@PCP & SpRef@RN3 (P)(M) (S)
National ID:	784-1988-9806024-3	Service Date:	14-Jun-2022 08:14:48 PM	Radiology:	Covered
Regulator Member ID:	I013-002-115590424-01	Patient's Tel No:	971506781433		
Policy Holder:	DANIA PROP MGMT AND CONSULTANCY CO LLC	Threshold Limit:			
Payer Name:	INS013 - MetLife	Class:	B		
		Out-Patient :			
Category:	Category1	Patient's File No:		Pharmacy:	Co-Part: 10%
		Consultation : Co-Part: 10% Max(20 AED)			
Gatekeeper:	No			Laboratory:	Covered

62 kg

Referral No:
Referred Service:

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): — 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:

Vital Signs: B/P 120/80 T 37c HR 80 RR 20 bpm

Assessment / Diagnosis: HTN ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspecteu

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:
	☐ 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: 05756224-001
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:	Date:	*Patient's Signature (parent if minor)*	Date: 14/06/2022
Tel / Fax (important):			
Signature & Stamp			

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