EASOAP FORM

NEXTCARE
Your Health Managed with Care

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

Patient Name:	Anastasiya Biassonava	Gender:	Female	Validity Between:	05/Mar/2022and04/Mar/2023
Card No:	7102978A546DC8DB	DOB:	11/Apr/1988	Coverage Information for:	Out-Patient
Pin #:	P/01/1306/2022/8316	Identity Card	784-1988-7782418-9	Network:	OIC-OP @ PCP & Sp Referral @ RN
National ID:	784-1988-7782418-9	Service Date:	15-Jun-2022 04:13:43 PM	Radiology:	Co-Part: 20%
		Patient's Tel No:	971504456089		
Policy Holder:	Anastasiya.Biassonava.	Threshold Limit:			
Payer Name:	INS008 - Orient Insurance PJSC	Class:	WARD		
		Out-Patient :			
		Patient's File No:		Pharmacy:	Co-Part: 30%
Gatekeeper:	No	Consultation : Co-Part: 20%		Laboratory:	Co-Part: 20%

Referral No:
Referred Service: 1 DAY Sick leave NKDA

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): Nocturia Fever Polyuria During — 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 100/70 T 37.3 HR 88 RR 20 b/m

Assessment / Diagnosis: UTI ☐ 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, Urine R/E, Lipid, TSH	

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: 15 06 2022

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

7:30 PM