eASOAP FORM

nextcare

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

Patient Name:	UMMA HUNY SUMA DELOWA	Gender:	Female	Validity Between:	29/Jan/2022and07/Jan/2023
Card No:	BEAFE8B3DED067A7	DOB:	01/Jan/1998	Coverage Information for:	Chronic Out
Pin #:		Identity Card	784-1998-0850387-6	Network:	NT-OP@PCP&SR@RN3 DXB Ex.AG
National ID:	784-1998-0850387-6	Service Date:	05-Aug-2022 04:33:42 PM	Radiology:	Co-Part: 20%
Regulator Member ID:	I018-002-117633639-01	Patient's Tel No:	-		
Policy Holder:	WEFIX AUTO GENERAL REPAIRING	Threshold Limit:			
Payer Name:	INS018 - Noor Takaful Family PJSC	Class:	Ward		
Category:	CAT A-LSB	Chronic Out :			
Gatekeeper:	No	Patient's File No:		Pharmacy:	Co-Part: 30%
		Chronic Conditions : Waiting Period: 6 Months Counting from Beneficiary Start Date,Pre Certification CAP: 1 AED Per Claim		Laboratory:	Co-Part: 20%
		Consultation : Co-Part: 20%			
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patient (Chief Complaint): Bleeding nose @ 36 weeks gestation — Date of Symptoms/illness started: DD MM YYYY

Past Medical Surgical History? ☐ YES ☐ NO — N/A — Date of Symptoms/illness started: DD MM YYYY

Obs/Gyn Claims — Date of Symptoms/illness started: DD MM YYYY

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

OBJECTIVE ASSESSMENT

Clinical Findings:

Vital Signs: B/P | T | HR | RR

Assessment / Diagnosis: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected

Indicate diagnosis not symptom

1. ? Epistaxis
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:	Refer to ENT.
	☐ 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. Marvie Fayi
Dental Practitioner
DHA No: 97086408-001
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: DD / MM / YYYY			
Signature & Stamp		*Patient's Signature (parent if minor)*	Date: 05 08 2022	

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