

REMIBURSEMENT ASOAP FORM

24 hour Tel: 011-0008103 , Fax: 02-22908220 –Office Number during Business Hours:02-24182564

Please complete Clearly (All Fields Mandatory)

Form No.

ADMINISTRATIVE

Healthcare Provider: مقدم الخدمة		Patient's Name: اسم المريض	
Date Of Service: ___/___/___ التاريخ dd mm yyyy		Patient's Tel: تليفون المريض	DOB: ___/___/___ تاريخ الميلاد dd mm yyyy
Card No. (Mandatory) رقم بطاقة التأمين الطبي		Sex: <input type="checkbox"/> F <input type="checkbox"/> M ذكر انثى	Patient's Employer: (Mandatory) جهة العمل

SUBJECTIVE (To be completed by physician)

Symptom(s) As described by Patient(Chief Complaint) الاعراض	
Date of Present Symptom Onset: ___/___/___ تاريخ بداية العرض dd mm yyyy	
What date did the Patient first feel same/similar Symptom(s): ___/___/___ تاريخ اول مرة شعر فيها المريض بالاعراض من قبل dd mm yyyy	
Is the Patient under any type of treatment? <input type="checkbox"/> yes <input type="checkbox"/> No If Yes, indicate what Assessment and since when: هل يتلقى المريض أى علاج إذا نعم ما نوع العلاج ومنذ متى الفحص السريري، التشخيص والعلاج	

OBJECTIVE/ASSESSMENT (To be completed by Physician)

Clinical Finding : Vital Signs: <input type="checkbox"/> B/P: <input type="checkbox"/> T: <input type="checkbox"/> IIR: <input type="checkbox"/> RR:	
Cause : <input type="checkbox"/> Physical <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive <input type="checkbox"/> Psychiatric <input type="checkbox"/> Dental <input type="checkbox"/> Work Related <input type="checkbox"/> Other	
Assessment/Diagnosis: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected	
Diagnosis Code	
1-	
2-	
3-	
Is Assessment/Diagnosis related to anther Assessment? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, specify (I.e. Retinopathy related to Diabetes)	

Medical PLAN *Itemized Original Invoice and Applicable Prescription/ Reports must be enclosed to consider claim.*

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory	Cost
TOTAL CHARGES			

Was In –patient Required? Length of Stay _____ Indicate Provider _____ Cost _____	
Discharge Summary, Itemized Invoice, Reports & Receipts Attached?	
Treating Physician Name : _____ Tel/Fax: _____ Signature & Stamp: _____	I hereby authorize any Healthcare provider, Insurance, Employer or other Organization to release any information regarding my medical condition & history to NEXtCARE for the purpose of determining insurance benefits.
	Patient Signature(Parent if minor) _____ Date _____