

REIMBURSEMENT ASOAP FORM

24 hour Tel: 04-2869311, Fax: 04-2868711 - Office Number during Business Hours: 04 - 2868722

ADMINISTRATIVE (To be completed by Patient)

Healthcare Provider:	Patient's Name :
Date of Service : dd _____ mm _____ 200 _____	Patient's Tel. :
Policy No. _____ Card No. _____	DOB: dd _____ mm _____ yyyy _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Address to which payment should be sent:	

SUBJECTIVE (To be completed by Patient or Physician)

Symptom(s) As Described by Patient (CHIEF COMPLAINT)
Date of Present Symptom Onset: dd _____ mm _____ 200 _____
What date did the Patient first feel same / similar Symptom/s : dd _____ mm _____ yyyy _____
Is the Patient under any type of Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, indicate what Assessment and since when:</i>

OBJECTIVE / ASSESSMENT (To be completed by Physician)

Clinical Findings:	Vital Signs: B/P: _____ T: _____ HR: _____ RR: _____
Cause: <input type="checkbox"/> Physical 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 <i>INDICATE DIAGNOSIS NOT SYMPTOM</i>	DIAGNOSIS CODE
1. _____	
2. _____	
3. _____	
Is Assessment / Diagnosis related to another Assessment ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, specify: (i.e. Retinopathy related to Diabetes)</i>	

MEDICAL PLAN (To be completed by Physician)

* ITEMIZED ORIGINAL RECEIPTS AND APPLICABLE PRESCRIPTIONS / REPORTS / RESULTS 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 / Radiology / Other	Cost
TOTAL CHARGES			

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



Reimbursement Claims Intake form

Name of patient	
Card number	
Date of birth	
Principal name	
Principal ID #	
Entity	

Submitted documents: Yes No

Filled reimbursement claim form:

Results of laboratory investigations:

Results of radiology investigations:

Original prescription:

Original invoices, receipts with itemizations:

Medical reports, surgical reports (if needed):

Missing documents to be provided:

Claim Status:

Documents complete: Yes No

Checked by: _____ Date: _____