MEDICAL EXPRESS

ASOAP FORM

NEXtCARE

Authorization Number _____

Dear Doctor: In order to verify Medical Insurance Claims Coverage for your Patient, kindly provide the following information.
This form will be handled with strict confidentiality by our team of professional physicians/nurses and medical claims experts.
Please fax this form to: 01-577 205 or 01-577 206. Please write the Authorization number given by our Claim Processors on the above area.
Should you have any questions, please contact MedEx/NextCare Call Center at: 01-577 200

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:
Consultation Date: / / 200_	Patient Tel: DOB: / / Sex: ☐ M ☐ F
Card Number:	Insurance Co./Employer's Name:

SUBJECTIVE

Symptom(s) As Described by the Patient *(CHIEF COMPLAINT):*	
Date of Present Symptom Onset: / / 200_	What date did the Patient first feel same/similar Symptom/s: / /
Previous Medical/Surgical History:	Indicate what Assessment and since when:
Is the Patient under any type of Treatment? ☐ Yes ☐ No	If yes, indicate what Assessment and since when:

OBJECTIVE / ASSESSMENT (to be filled by the Physician only)

Clinical Findings : Vital Signs: B/P:_____T:_____ HR:_____ RR:_____

Cause : ☐ Physical Illness ☐ Accident ☐ Maternity ☐ Preventive ☐ Psychiatric ☐ Dental ☐ Work related ☐ Other

Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected *INDICATE DIAGNOSIS NOT SYMPTOM*	DIAGNOSIS CODE
1.	
2.	

Is Assessment/Diagnosis related to another Assessment ☐ Yes ☐ No If yes, specify: *(e.g. Retinopathy related to Diabetes)*

MEDICAL PLAN (to be filled by the Physician only)

☐ Laboratory/Radiology or others (pls. specify)	☐ Medications
Name of Provider:	***Name of Pharmacy:***

Is the following Required? ☐ Surgery ☐ Endoscopy ☐ Physiotherapy ☐ Other Procedures (If yes, please specify code)

Is In-patient Required? ☐ Yes ☐ No

Admission Date: Length of Stay: Code: Hospital: Estimated Cost:

Treating Physician Name: **Tel / Fax (Important)** Signature: _____	*I hereby authorize any Healthcare Provider, Insurer, Employer other Organization to release any information regarding my medical condition & history to MedEx/NEXtCARE for the purpose of determing insurance benefits.* Patient Signature (Parent if minor) _____ *Date* _____