I.S.O.A.P FORM

IRIS
HEALTH SERVICES

*Kindly provide the following information which will be handled with strict confidentiality by our team of doctors. Please forward this claim form to 24 hour Tel:- 04 _____, Fax: - 04 _____. (**All Fields are Compulsory**)*

eRX No. _____ **CLAIM FORM NO._____**

Healthcare Provider's Name :	**Br./Location**
Policy Number :	**Provider Contact No.**
Patient's Name :	
DOB: / / **Sex** ☐ Male ☐ Female	**Patient Contact No.**
Patient Email Address : -	
Patient's Card No.	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Insurance Company Name :	

SUBJECTIVE

Patient Symptoms:
Date symptoms first noticed : / / **Treatment Date: / /**
LMP Date if Applicable: / / **Is the patient under any type of treatment?** ☐ **YES** ☐ **NO** **If yes, indicate what assessment and since when:**

OBJECTIVE / ASSESSMENT

Clinical Findings & Symptoms: **Vital Signs : B/P_____ T:_____ HR: _____ RR:_____**
Assessment / Diagnosis: ☐ Acute ☐ Chronic ☐ Pre-Existing ☐ Dental ☐ Optical ☐ Maternity
Indicate Final Diagnosis: **ICD Code :-**

MEDICAL PLAN

☐ **Pharmacy**	☐ **Laboratory**
☐ **Radiology**	☐ **Others**

Original Itemized Invoice and Related Prescriptions, Reports, & Results must be enclosed to consider claim.

Patient Declaration / Consent: I hereby confirm that the information I have given along with all submitted claim's documents are correct and true, Additionally, I the undersigned authorize and request any hospital, physician, any other health provider or any insurance company to furnish IRIS Health Services LLC with the complete information including copies of their records in connection with medical care, treatment, examination, advice or other service provided to me or to my dependents. **Any copy of this consent should be considered as the original.**

Insured Member's Signature (Parent if minor) dd___/mm___/yy_____ Physician Signature & Stamp