No.

STANDARD SOAP

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Payer: _____

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Dear Doctor : We are pleased that our member is consulting you for medical care and kindly ask you to complete this SOAP form while complying with all MedNet's Network procedures. Thank you

SUBJECTIVE	OBJECTIVE

CONSULTATION	ASSESSMENT

PLAN	
	PHARMACEUTICALS

PLAN	
	DIAGNOSTIC PROCEDURES

Physician's Name: _____

Telephone No.: _____

Date: _____

STAMP & SIGNATURE

CARD HOLDER'S SIGNATURE

"I hereby authorise any MedNet personnel to access my medical file"

Distribution: White to Physician, Pink to Pharmacy, Yellow to Diagnostic Center/ Laboratory, Green to Cardholder

MedNet Claims Center: 800 4882 (24-hour hotline), Fax: 800 4883
E-mail: medicalunit@mednet-uae.com