NEXTCARE Dental Form

eASOAP FORM

Kindly provide the following information which will be handled with strict confidentiality by our team of doctors. Please forward the ASOAP form to: 24 hour Tel: 04-2095900; Fax: 04-2095990/1/2/3. Office Number during Business hours: 04-2095200

ADMINISTRATIVE

ADMINISTRATIVE The member is allowed for **Dental** at the **CITICARE MEDICAL CENTER LLC**

Patient's Name :**ARWA ARWA**	Gender :**Female**	Validity Between :**01-Jan-2024 - 31-Dec-2026**
Card No: **A417-E349-4452-B10D**	DOB :**1/1/2020 12:00:00 AM**	Coverage Information for:**Dental**
Pin #:	Identity Card :**784-2020-1321238-0**	
National ID :**784-2020-1321238-0**	Service Date: **05-Nov-2024**	Network :**Default Scheme**
	Patient's Tel No: **0503145470**	Dental : **0 :0 :0 :0 :20 :0 :0**
Policy Holder: **NEXTCARE ENAYA**	Threshold Limit: **0**	
Payer Name: **ENAYA**		
Category:	Class:	Patient's File No: **44807**
DMP:	Gatekeeper:	
Referral No:	Referred Service:	

To be completed by Attending DENTIST

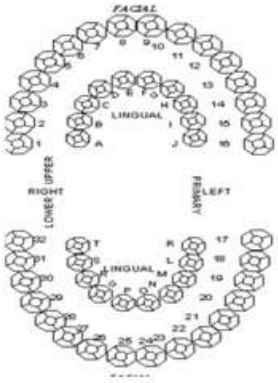
Duration of illness:

Chief Complaint & Main Symptoms:
pain in the lower lift side

Principle & Secondary Code:
K02.62 2nd Code: 3nd Code:

Diagnosis: Dental caries on smooth surface penetrating into dentin

Other Conditions Diagnosis



Please Tick (X) Where Appropriate:

☐	RTA	☐	Work Related	☐	Sports Related
☐	Orthodontics \ Esthetics	☐	Congenital\ Developmental		
☑	Check up	☐	Cleaning		

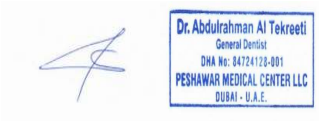
Specify the recommended investigations and/or procedures using the tooth number as shown on the teeth map above

Code #	Description/ Service	Tooth no. / Area	Cost
D0220	intraoral - periapical first radiographic image **(Dental Co.Pay)**	K	**32.00**
D0150	Comprehensive Oral Evaluation- New Or Established **(Dental Co.Pay)**		**96.80**
			128.80

I hereby certify that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition and history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.

Treating Dentist Name: **Abdulrahman**
Tel / Fax (important): **0563232355** Date: **05-11-2024**

Signature & Stamp 	Patient's Signature (parent if minor) Date: **05-11-2024**

Note: Claims must be submitted along with supporting documents within 30 days from date of service

Disclaimer: NEXtCARE ASOAP form is used for claim creation purposes. The data contained here should always be carefully reviewed. NEXtCARE will not be held responsible for misuse of claims
submission's or any adverse effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion
will be given by the NEXTCARE claims doctors