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 :**Fahad Ali Ahmad Mohammad Alblooshi** | Gender :**Male** | Validity Between :**01-Jan-2024 - 31-Dec-2026** |
| Card No: **8EA0-0C2B-2BBF-6608** | DOB :**9/15/1984 12:00:00 AM** | Coverage Information for:**Dental** |
| Pin #: | Identity Card :**784-1984-0254626-5** | |
| National ID :**784-1984-0254626-5** | Service Date: **05-Apr-2025** | Network :**Default Scheme** |
| | Patient's Tel No: **0556039392** | Dental : **0 :0 :10 :0 :0 :0 :0** |
| Policy Holder: **NEXTCARE ENAYA** | Threshold Limit: **0** | |
| Payer Name: **ENAYA** | | |
| Category: | Class: | Patient's File No: **37437** |
| DMP: | Gatekeeper: | |
| Referral No: | Referred Service: | |

To be completed by Attending DENTIST

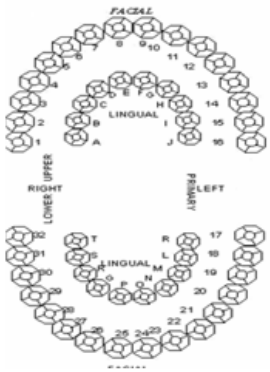
Duration of illness: since 1 week

Chief Complaint & Main Symptoms:
broken restoration

Principle & Secondary Code:
K04.1 2nd Code: 3nd Code:

Diagnosis: Necrosis of pulp

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 |
|---|---|---|---|
| D0150 | Comprehensive Oral Evaluation- New Or Established **(Dental Co.Pay)** | | **121.00** |
| D0220 | intraoral - periapical first radiographic image **(Dental Co.Pay)** | | **40.00** |
| | | | **161.00** |

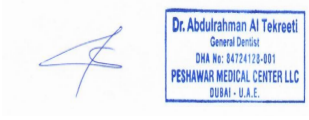
I hereby certify that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.

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: **05-04-2025**

Signature & Stamp




Patient's Signature (parent if minor)

Date: **05-04-2025**

**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