eASOAP FORM

ADMINISTRATIVE The member is allowed for **Out Patient** at the **CITICARE MEDICAL CE**

Patent Name:	**FATIMA ABDALLA ISMAIL ALBAROUT ALBAROUD**	Gender:	**Male**	Validity Between:	**01/01/2024 and**
Card No:	**985A-972B-1668-A884**	DOB:	**12/1/1998 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ans MEDGULF**
Natonal ID:	**784-1998-0985424-5**	Service Date:	**05-May-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0501684070**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**46722**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						**Date of Sympton**	
Complaint						DD	MM
the pt came here wih severe pain in upper right jaw,							
Past Medical Surgical History?		◯ Yes		◯ No		**Date of Sympton**	
						DD	MM
Obs/Gyn Claims						**Date of Sympton**	
						DD	MM
☐ Para	☐ Gravida:	☐ AB:	LMP:	Marital Status:	Marital Date:		

What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy

Is the Patient under any type of Treatment? ◯ Yes ◯ No if yes, indicate what Assessment and since when:

OBJECTIVE / ASSESSMENT ***(To be completed by Physician)***

Clinical Findings :	Vital Signs : B/P : 120 T : 36.8 HR : 18

Assessment/Diagnosis : ◯ **Acute** ◯ **Chronic** ◯ **Confirmed** ◯ **Suspected**

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	K02.9	Dental caries, unspecified

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

Accident or illness due to work?	Injury due to road accident?	Describe how the accident or work related injury/illn
◯ Yes ◯ No	◯ Yes ◯ No	

Date of accident or beginning of illness:	

MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type
D0150	Comprehensive Oral Evaluation- New Or Established Patient	Dental Co.Pay

Code	Generic	Duration	Instructions
No Prescriptions History Found			

○ Pharmacy:	Estmated Costs	○ Laboratory / Radiology:	Estmated Costs
Is the following required	○ Surgery:	○ Endoscopy:	
	○ Physiotherapy:	○ Other Procedures:	
		If yes please specify	

Is In-patient Required ? Length of Stay	Indicate Provider
I hereby certfy that all informaton mentoned 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 ot to release any informaton regarding my medical conditon and hist for the purpose of determining insurance benefts. Medical manage responsibility of doctor and the patent.*
Treating Physician Name : **Abdulrahman**	
Tel / Fax (important):	
Signature & Stamp Dr. Abdulrahman Al Tekreeti General Dentist DHA No: 84724128-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.	***Patient's Signature(Parent if minor)***
Date :	Date : 05-May-2025

Note: Claims must be submited along with supportng documents within 30 days from date of service

Disclaimer: NEXtCARE ASOAP form is used for claim creaton purposes. The data contained here should always be carefully rev will not be held responsible for misuse of claims submission's or any adverse efects caused due to the claims submissions. NE responsibility for any discrepancies or errors contained in this pre-printed datasheet and fnal opinion will be given by the NEX doctors.