

eASOAP FORM



ADMINISTRATIVE

The member is allowed for Out Patient

at the CITICARE MEDICAL CENTER LLC

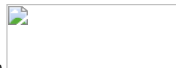
Patent Name:	SHIREEN IQBAL IQBAL MUHAMMAD ALI MUSJI	Gender:	Female	Validity Between:	31/08/2024 and 31/12/2026
Card No:	692B-D7E2-6B67-4F96	DOB:	1/1/1967 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identity Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1967-5139106-9	Service Date:	07-May-2025	Radiology:	Covered
Policy Holder:		Patent's Tel No:	0555358989		
Payer Name:	ENAYA	Threshold Limit:			
		Class:	Normal		
Category:	Category B	Out-Patent :		Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Patent's File No:	39185	Laboratory:	Covered
Referral No:		Consultaton :			
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):				Date of Symptoms/illness started	
Complaint				DD	MM
Taking X-ray from upper and lower right jaw.and detected caries in tooth number 30 and 31(lower right 6 and 7)				YYYY	
Past Medical Surgical History?		☐ Yes	☐ No	Date of Symptoms/illness started	
				DD	MM
				YYYY	
Obs/Gyn Claims				Date of Symptoms/illness started	
				DD	MM
				YYYY	
☐ 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 : 153	T : 37.7	HR : 71	RR
		: 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/illness occur:		
☐ 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	Price		
D0150	Comprehensive Oral Evaluation- New Or Established Patient	Dental Co.Pay	121.0000		
Code	Generic	Duration	Instructions		
0003-238002-1451	(DICLOFENAC ACID : 18 MG) CAPSULES (HARD GELATIN)	7	Take 1Tablets 3 Time(s) per Day For 3 Day(s) others		
☐ Pharmacy:	Estimated Costs	☐ Laboratory / Radiology:	Estimated Costs		
Is the following required	☐ Surgery:	☐ Endoscopy:			
	☐ Physiotherapy:	☐ Other Procedures:			
	If yes please specify				

Is In-patient Required ? Length of Stay		Indicate Provider		Estimate Cost
I hereby certify 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 other Organizaton to release any informaton regarding my medical conditon and history to NEXTCARE for the purpose of determining insurance benefets. Medical management is the sole responsibility of doctor and the patent.		
Treating Physician Name : Abdulrahman				
Tel / Fax (important):				
 Signature & Stamp 		 Patient's Signature(Parent if minor)		
Date :		Date : 07-May-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 creaton 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 fnal opinion will be given by the NEXtCARE claims doctors.