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 :**EHAAN SAMIR**	Gender :**Female**	Validity Between :**12-Sep-2024 - 11-Sep-2025**
Card No: **05D8-81A9-D2F7-7042**	DOB :**12/24/2020 12:00:00 AM**	Coverage Information for:**General**
Pin #:	Identity Card :**784-2020-1698336-7**	
National ID :**784-2020-1698336-7**	Service Date: **14-May-2025**	Network :**Default Scheme**
	Patient's Tel No: **0557008996**	Dental : **20 :20 :30 :0 :0 :0 :0**
Policy Holder: **NEXTCARE -OP PCP**	Threshold Limit: **0**	
Payer Name: **ORIENT INSURANCE P.J.S.C**		
Category:	Class:	Patient's File No: **44832**
DMP:	Gatekeeper:	
Referral No:	Referred Service:	

To be completed by Attending DENTIST

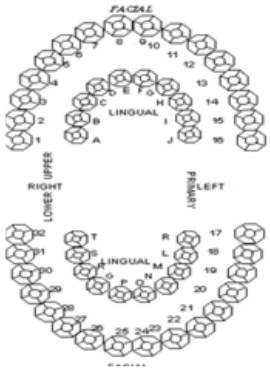
Duration of illness:

Chief Complaint & Main Symptoms:

Principle & Secondary Code:
R05, R11.2, E55.9 2nd Code: 3nd Code:

Diagnosis: Cough, Nausea with vomiting, unspecified, Vitamin D deficiency, unspecified

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
9	GP Consultation **(General Consultation)**	NA	**20.00**
			20.00

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: **Dr Bushra**

Tel / Fax (important): **0552397911** Date: **14-05-2025**

Signature & Stamp

Dr. Bushra Mufti
General practitioner
DHA: 75646242-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Patient's Signature (parent if minor) Date: **14-05-2025**

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