eASOAP FORM

NEXtCARE
Your Health Managed with Care

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

Patent Name:	**Theyab Saeed Khalfan Bin Suroor**	Gender:	**Male**	Validity Between:	**01/01/2024 and 31/12/2026**
Card No:	**513E-DFDB-D7BF-A0C0**	DOB:	**6/18/1993 12:00:00 AM**	Coverage Informaton for:	**Out Patient**
Pin #:		Identty Card:		Network:	**RN UAE (Al Ansari-AUH)-MEDGULF**
Natonal ID:	**784-1993-7590318-6**	Service Date:	**09-Jul-2025**	Radiology:	**Covered**
		Patent's Tel No:	**0559887408**		
Policy Holder:		Threshold Limit:			
Payer Name:	**ENAYA**	Class:	**Normal**		
		Out-Patent :			
Category:	**Category B**	Patent's File No:	**47352**	Pharmacy:	**Co-Part: 20%**
Gatekeeper:	**No**	Consultaton :		Laboratory:	**Covered**
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):

Complaint
because of inflamation and bleeding of the gums we did scaling and polishing
scaling and polishing

Date of Symptoms/illness started

DD	MM	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 :	T :	HR :	RR :

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

INDICATE DIAGNOSIS NOT SYMPTOM

Type	Code	Diagnosis
Primary	Z01.21	Encounter for dental exam and cleaning w abnormal findings

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:		

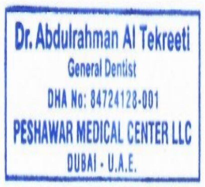
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

CPT Code	Treatment	Type	Price
D1110	Prophylaxis - Adult	Dental Co.Pay	200.0000

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 Estimate Cost	
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 other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefts. 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 : 09-Jul-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 reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse efects 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.