eASOAP FORM

nextcare

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 The member is allowed for **Dental** at the **Dentistree Dental Clinic**

Patient Name:	**Anas Foead Dast Avar**	Gender:	**Male**	Validity Between:	**01/Jan/2024and31/Dec/2026**
Card No:	**9FC156C08C5BCA26**	DOB:	**29/Nov/2016**	Coverage Information for:	**Dental**
Pin #:		Identity Card	**784-2016-0850303-9**		
National ID:	**784-2016-0850303-9**	Service Date:	**26-Dec-2024 06:55:23 PM**	Network:	**ENAYA Silver**
Regulator Member ID:	**I001-002-112604809-01**	Patient's Tel No:	**971569314981**		
		Threshold Limit:	**1000 AED**	Dental :	**Co-Part: 20%**
Policy Holder:	**DUBAI MUNICIPALITY**	Class:	**C EXPATS**		
		Gatekeeper:	**No**		
Payer Name:	**INS001 - ENAYA**				
				Patient's File No:	
Referral No:		Referred Service:			

To be completed by Attending DENTIST

Duration of illness:

Chief Complaint & Main Symptoms:

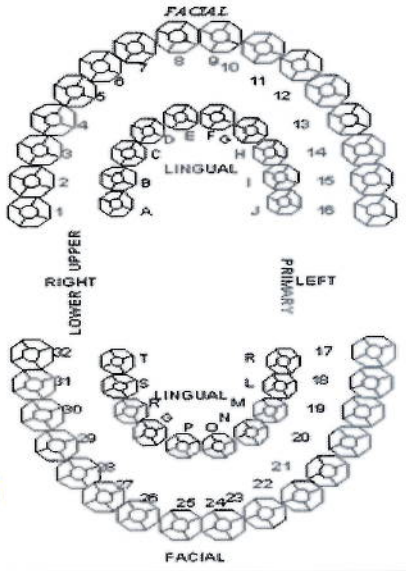
Pain on biting & sweet & bad breath

Diagnosis: K04.01 + K02.62 + K05.10

Principle Code: | 2nd Code: | 3rd Code:

Other Conditions Diagnosis:

Chronic gingivitis + Reversible pulpitis Caries of Pendulus



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
D1120	Scaling & Polishing (child)		162
D2393	3 surf # L	(OMD)	209.90
D3240	pulpotomy # K		225
D2394	4 surf # K	(OMDL)	258
		TOTAL	

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.

Dr. Hengameh Shadafzah
General Dentist
DENTISTREE DHA-7725976-004
DENTISTREE DENTAL CLINIC

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:					
Tel / Fax (important):		Date:	DD MM YYYY		
Signature & Stamp				*Patient's Signature (parent if minor)*	Date: DD MM YYYY

Note: Claims must be submitted along with supporting documents within 30 days from date of service