ASOAP FORM

NEXtCARE®
Your Health Managed with Care

FORM No.

Kindly provide the following information which will be handled with strict confidentiality by our team of doctors. Please forward this ASOAP form to:
24 hour Tel: 04-6056800, Fax : 04-6056801/2/3 - Office Number during Business Hours: 04-6056700

ADMINISTRATIVE

Please complete clearly ***(All fields mandatory)***

Healthcare Provider : Patient's Name : Patient's File No. # :

Date of Service : ____ / ____ / 200 ____ (dd / mm) **Patient's Tel :** DOB: ____ / ____ / ____ (dd / mm / yy) Sex: ☐ F ☐ M

Card No. **(Mandatory)** | | | | | | | | | | | | | **Patient's Employer:** **(Mandatory)**

Insurance Co. ***(Mandatory)***

☐ Dubai Goverment ☐ Dubai Holding ☐ Al Sagr ☐ Arab Orient ☐ Jumeirah ☐ Al Fujairah ☐ NASCO ☐ RAKNIC
☐ Dubai National ☐ Alliance ☐ RTA ☐ AMAN ☐ MedGulf/Medi Visa ☐ Al Buhairah ☐ United ☐ Other ____

Alliance

SUBJECTIVE

Symptom(s) As Described by Patient *(CHIEF COMPLAINT)*

Date of Present Symptom Onset: ____ / ____ / ____ (dd / mm / yy) What date did the Patient first feel same / Similar Symptoms/s: ____ / ____ / ____ (dd / mm / yy)

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

OBJECTIVE / ASSESSMENT

Clinical Findings: Vital Signs: B/P: ____ T: ____ HR: ____ RR: ____

Assessment / Diagnosis: ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected ☐ Injury Cause ____
INDICATE DIAGNOSIS NOT SYMPTOM

1.

2.

MEDICAL PLAN

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

☐ **Pharmacy:**	*Estimated Cost*	☐ **Laboratory / Radiology**	*Estimated Cost*

Is the following Required? ☐ Surgery ☐ Endoscopy ☐ Physiotherapy ☐ Other Procedures *(If yes, please specify)*

For NEXtCARE use only

As per the terms of agreement and related documentation:

Approved ☐ Not eligible ☐

Ded:____ Dhs. No. of Days:____/ or Daycase: ____

Copar: ____%

____ NEXtCARE Claims Center

____ / ____ / ____ (dd / mm / yy)

Note : Approval valid only for 7 days at ____

Is In-patient Required? Length of Stay ____ Indicate Provider ____ Estimated Cost ____

I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to NEXtCARE for the purpose of determining insurance benefits. Medical management is the sole responsibility of doctor and the patient.

Treating Physician Name : ____

Tel/Fax (Important) : ____

Signature & Stamp ____ *Patient's Signature (Parent if minor)* ____ ____ / ____ / ____ (dd / mm / yy)

Claims must be submitted along with supporting Documents within 30 days from date of service.

White Copy for Clinic **Yellow Copy for Pharmacy** **Pink Copy for Diagnostic Center**