NEXtCARE®
Your Health Managed with Care

ASOAP FORM

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: +971 4 2708800, Fax: +971 4 2708592

Please Complete Clearly (All Fields Mandatory) **FORM No. NC:**

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		Patient's File No. #:
Date of Service: dd /mm /yyyy	Patient's Tel:	DOB: dd/mm/yyyy	Sex: ☐ **F** ☐ **M**
Card No:		Patient's Employer:	
Insurance Company:			

SUBJECTIVE /ASSESSMENT

Symptom(s) As Described by Patient (CHIEF COMPLAINT)	
Date of Present Symptom Onset: ____ / _____ / _____ *dd mm yyyy*	Date Symptom First Appeared: ____ / _____ / _____ *dd mm yyyy*
Is the Patient under any type of treatment / Meds: ☐YES ☐ NO *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	*Cost*	☐ Laboratory / Radiology / Other	*Cost*
TOTAL CHARGES			

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** _____	
Treating Physician Name:	*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.*
Tel / Fax:	
Signature & Stamp:	*Patient's Signature (Parent if minor)* / *Date*