NEXtCARE®
Your Health Managed with Care

REMIBURSEMENT ASOAP FORM

24 hour Tel:19154, Fax: 02-24632303-4

ADMINISTRATIVE

Healthcare Provider: مقدم الخدمة	**Patient's Name:** اسم المريض		
Date Of Service:___/___/____ التاريخ *dd mm yyyy*	**Patient's Tel:** تليفون المريض	DOB:___/___/___ تاريخ الميلاد *dd mm yyyy*	Sex: ☐F ☐M ذكر انثى
Card No. *(Mandatory)* رقم بطاقة التأمين الطبى			**Patient's Employer:** *(Mandatory)* جهة العمل

SUBJECTIVE (*To be completed by physician*)

Symptom(s) As described by Patient(Chief Complaint) الاعراض
Date of Present Symptom Onset: ___/___/____ تاريخ بداية العرض dd mm yyyy
What date did the Patient first feel same/similar Symptom(s): ___/___/____ تاريخ اول مرة شعر فيها المريض بالاعراض من قبل dd mm yyyy
Is the Patient under any type of treatment? ☐yes ☐No *If Yes, indicate what Assessment and since when:* هل يتلقى المريض أى علاج إذا نعم ما نوع العلاج ومنذ متى

OBJECTIVE/ASSESSMENT (*To be completed by Physician*) الفحص السريرى، التشخيص والعلاج

Clinical Finding : **Vital Signs:** ☐B/P:_____ ☐T:____ ☐IIR:____ ☐RR:_____	
Cause :☐ **Physical** ☐**Illness** ☐ **Accident** ☐**Maternity** ☐**Preventive**☐ **Psychiatric** ☐**Dental** ☐*Work Related*☐*Other*	
Assessment/Diagnosis:☐Acute ☐ Chronic ☐Confirmed ☐Suspected	*Diagnosis Code*
1-	
2-	
3-	
Is Assessment/Diagnosis related to anther Assessment? ☐ yes ☐No *If yes, specify (I.e. Retinopathy related to Diabetes)*	

Medical PLAN *Itemized Original Invoice and Applicable Prescription/ Reports must be enclosed to consider claim.*

☐ **Consultation**	**Cost**	☐ **Physiotherapy**	**Cost**
☐ **Pharmacy**	**Cost**	☐ **Laboratory**	**Cost**
TOTAL CHARGES			

*Was In –patient Required? Length of Stay*_____ *Indicate Provider* _____*Cost*_____

Discharge Summary, Itemized Invoice, Reports & Receipts Attached?

*Treating Physician Name :*_____
*Tel/Fax:*_____
*Signature &Stamp:*_____

I hereby authorize any Healthcare provider, Insurance, Employer or other Organization to release any information regarding my medical condition &history to NEXtCARE for the purpose of determining insurance benefits.

Patient Signature(Parent if minor) *Date*