NEXtCARE®
Your Health Managed with Care

REIMBURSEMENT FORM

24 hour Tel: 04-2708800, Fax: 04 2708592

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

ADMINISTRATIVE

Healthcare Provider:	Patient's Name: NATASHA AMAR		
Date of Service: dd /mm /yyyy	Patient's Tel:	**DOB** dd/mm/yyyy	**Sex:** ☐ F ☐ M
Emirates ID No:		Email address: (Mandatory)	
Insurance Company:			
Account Name:	UAE IBAN Number:		
UAE Bank Name:	UAE Swift Code:		

SUBJECTIVE ***(To be completed by Physician)***

Symptom(s) As Described by Patient (CHIEF COMPLAINT) c/o food lodgement & sensitivity
Date of Present Symptom Onset: 11 (dd) / 2 (mm) / 2023 (yyyy)
What date did the Patient first feel same / similar symptom(s): 8 (dd) / 12 (mm) / 2022 (yyyy)
Is the Patient under any type of treatment / Meds: ☐YES ☐ NO *If yes, indicate what assessment and since when:*

OBJECTIVE / ASSESSMENT ***(To be completed by Physician)*** **Vital Signs T: P: R: B/P:**

Past Medical & Surgical History:	
Clinical Details & Description of Present Case:	
Cause: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related ☐Acute ☐Chronic ☒Confirmed ☐Suspected ☐Other	
Assessment / Diagnosis: *INDICATE DIAGNOSIS NOT SYMPTOM*	**Diagnosis Code**
1. K02-62 - Dental Caries into dentin #19	K02-62
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? ☐ **YES** ☐ **NO** *If yes, specify: (i.e. Retinopathy related to Diabetes*	

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

☐ **Consultation**	*Cost*	☐ **Physiotherapy**	*Cost*
Composite restoration #19	300/-		
☐ **Pharmacy**	*Cost*	☐ **Laboratory / Radiology / Other**	*Cost*
TOTAL CHARGES	300/-		

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

- ***Discharge Summary: Itemized Invoices, Reports & Receipts Attached?***

Treating Physician Name: Dr. Tarang Azeem Subba	*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.*
Name & Address of Facility:	
Tel / Fax:	
Email:	
Signature & Stamp:	*Patient's Signature (Parent if minor)* / *Date*

Dr. Tarang Azeem Subba
Specialist Periodontics
DENTISTREE DHA-01357287-001
DENTISTREE DENTAL CLINIC