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: Dentistree Dental Clinic	Patient's Name: Natasha Amar		
Date of Service: dd /mm /yyyy 09/05/2023	Patient's Tel:	DOB dd/mm/yyyy 28/12/1987	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 sensitivity in upper left back region & food lodgment in multiple areas.

Date of Present Symptom Onset: 09 / 05 / 2023 (dd / mm / yyyy)

What date did the Patient first feel same / similar symptom(s): 07 / 05 / 2023 (dd / mm / 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 penetrating to dentin.	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
D0330 ① OPG.	250/-		
D2391 ② Composite filling tooth #12	300/-		
☐ Pharmacy	Cost	☐ Laboratory / Radiology / Other	Cost
TOTAL CHARGES	550/-		

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

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

Treating Physician Name:

Name & Address of Facility:

Tel / Fax:

Email:

Signature & Stamp:

Dr. Tarona Azem Subba
Specialist Periodontics
DENTISTREE DHA-0135728?

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.

Patient's Signature (Parent if minor) | *Date*