

## REIMBURSEMENT FORM

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

Please Complete Clearly (All Fields Mandatory) FORM No: ADMINISTRATIVE Healthrand Providentul Unic Patient's Name: Maha Patient's Tel: 60 K DOB dd/mm/yyyy Sex: F F M Email address: Emirates ID No: 724-2013- 719 3959-2 (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) Date of Present Symptom Onset: What date did the Patient first feel same / similar symptom(s): mm уууу 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: R: B/P: Past Medical & Surgical History: Clinical Details & Description of Present Case: Cause: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related □Chronic □Confirmed □Suspected □Other Assessment / Diagnosis: INDICATE DIAGNOSIS NOT SYMPTOM **Diagnosis Code** 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 ☐ Pharmacy Cost ☐ Laboratory / Radiology / Other Cost AFN 200 TOTAL CHARGES Was In-patient Required? Length of Stay Indicate Provider Cost Discharge Summary: Itemized Invoices, Reports & Receipts Attached? I hereby authorize any Healthcare Provider, Insurer, Employer Treating Physician Name: or other Organization to release any information regarding my Name & Address of Facility: Privant medical condition & history to NEXtCARE for the purpose of determining insurance benefits. Tel / Fax: General Dentist DENTISTREE DHA-00148697-002 Signature & Stamp! REE DENTAL CLINIC

Patient's Signature (Parent if minor)

Date