

# REIMBURSEMENT FORM

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

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

**ADMINISTRATIVE**

Healthcare Provider: <u>Arabian Dental Clinic</u>	Patient's Name: <u>Nani Mary</u>		
Date of Service: <u>17-03-24</u>	Patient's Tel: <u>0503455931</u>	DOB <u>10/10/1987</u>	Sex: <input checked="" type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No: <u>781-1987-4602102-5</u>	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)

Date of Present Symptom Onset: 28 / 02 / 24  
dd / mm / yyyy

What date did the Patient first feel same / similar symptom(s): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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. Resin Based Core / # 8 [M, B]	K08.531 D2331
2. Resin Based " # 9 [M, B]	K08.531 D2331
3. Prophylaxis	K05.10 D1110

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

Cost	Cost
<input type="checkbox"/> Consultation	<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Laboratory / Radiology / Other
	Resin based filling - AED 500
	Prophylaxis - AED 150
	5

**TOTAL CHARGES** AED 1020

Was In-patient Required? Length of Stay \_\_\_\_\_ Indicate Provider \_\_\_\_\_ Cost \_\_\_\_\_

• Discharge Summary: Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name: <u>DR PEARL PINTO</u>	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: <u>Dr. Pearl Pinto General Dentist</u>	
Tel / Fax: <u>DENTISTREE DHA-04205785-003</u>	
Email: <u>DENTISTREE DENTAL CLINIC</u>	
Signature & Stamp: <u>[Signature]</u>	Patient's Signature (Parent if minor) _____ Date _____



# DENTISTREE DENTAL CLINIC

1,020.00

RECEIPT VOUCHER (No.REC-1006271)

Date:07-03-2024

Receive from Mr./Mrs./M/s. **2188 - Mansi Mistry**

The sum of Dhs. **One Thousand Twenty Dirhams and Zero Fils Only**

By Cash **1,020.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank:                      Cheque No.

Date: **07-03-2024**

Being

Made by **Gayle Reyes**

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# DENTISTREE DENTAL CLINIC

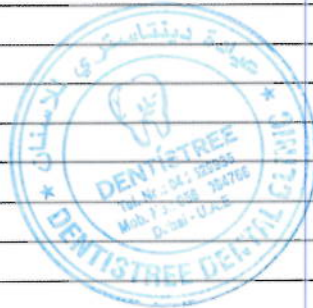
## TAX INVOICE

Reg TRN No : 100529934000003  
Facility Name : DentisTree Dental Clinic  
Address : Ground floor, Shop 3, Wasl Port Views 8, Al  
Mina Road, Jumeirah 1, Dubai  
042529935 / / 045641764

Policy No :  
Claim No :  
Doctor : Pearl Pinto  
Customer Name : Mansi Mistry  
Age / Gender : 37Y - 0M - 25D / Female  
Department :  
Rate Plan :  
Insurance Company : Cash  
MR # : 2188  
Customer VAT Reg  
No :

Invoice No : INV-1C006099  
Invoice Date : 07-03-2024  
Invoice Time : 07-03-2024  
Invoice Type : Outpatient  
Mode : Cash / Credit  
Referred By :  
Visit ID :  
Registered Date : 07-03-2024

SI No	Service Code	Treatment / Procedure	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D2331	resin-based composite - two surfaces, anterior	420.00	2	840.00	0.00	0	0.0000	840.00
2	D1110	prophylaxis - adult	180.00	1	180.00	0.00	0	0.0000	180.00
<b>Gross Amount (in AED)</b>									<b>1,020.00</b>
<b>Discount (in AED)</b>									<b>0.00 Fixed</b>
<b>Net Amount (in AED)</b>									<b>1,020.00</b>
<b>Net Sponsored Amount (in AED)</b>									<b>1,020.00</b>
<b>Tax on Net Sponsored Amount(in AED)</b>									<b>0.00</b>
<b>Total Sponsored Amount(in AED)</b>									<b>1020.00</b>
<b>Net Patient Amount (in AED)</b>									<b>1,020.00</b>
<b>Tax on Patient Amount(in AED)</b>									<b>0.00</b>
<b>Total Patient Amount(in AED)</b>									<b>1,020.00</b>
<b>Taxable Sale @ 5%(in AED)</b>									<b>0.00</b>
<b>Tax on 5%(in AED)</b>									<b>0.00</b>
<b>Taxable Sale @ 0%(in AED)</b>									<b>1020.00</b>
<b>Paid (in AED) (Cash)</b>									<b>-1,020.00</b>
<b>Balance (in AED)</b>									<b>0.00</b>
<b>Advance Balance (in AED)</b>									<b>0.00</b>



Prepared By Gayle Reyes