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: MARIUS SCHEIN		
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) K05.10 Chronic Generalised Gingivitis
Deposits on teeth and Bleeding gums.

Date of Present Symptom Onset: 03 / 07 / 2024 (dd / mm / yyyy)

What date did the Patient first feel same / similar symptom(s): 03 / 07 / 2024 (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:

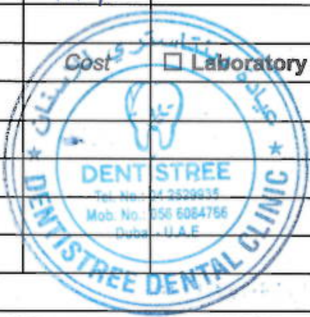
Cause: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related ☐Acute ☐Chronic ☒Confirmed ☐Suspected ☐Other

Assessment / Diagnosis: *INDICATE DIAGNOSIS NOT SYMPTOM*	**Diagnosis Code**
1. Chronic Generalised Gingivitis	K05.10
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
Oral Prophylaxis D1110	199		
☐ Pharmacy	Cost	☐ Laboratory / Radiology / Other	Cost
TOTAL CHARGES			



Was In-patient Required? Length of Stay________ Indicate Provider________ Cost

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

Treating Physician Name: Dr. Aditi Loomba, General Dentist	*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: DENTISTREE DHA-00189428-002	
Tel / Fax:	
Email: DENTISTREE DENTAL CLINIC	
Signature & Stamp: [signature]	Patient's Signature (Parent if minor) / Date