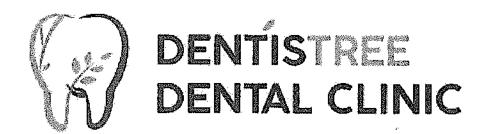


REIMBURSEMENT FORM

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

Please Complete Clearly (All Fields Mandatory) FORM No:

DMINISTRATIVE		Della alla Massa					
Healthcare Provider	re dental qu	Patient's Name	HITVIEU LI		w con	-/	
Date of Service: dd /mm		DOB dd/mm/ Email address:	уууу Бех	c: DF DM			
Emirates ID No:		- 4780790 - 7		(Mandatory)			
nsurance Company:		1					
Account Name:			BAN Number: Swift Code:				
JAE Bank Name:			Swift Code:				
UBJECTIVE (To be comp Symptom(s) As Described I	letea by Phys	IEE COMPLAINT	1				
Symptom(s) As Described i	by Fatterit (Ch	ILI COMI LANTI	1				
Date of Present Symptom	Onset:	1 / /	уууу				
What date did the Patient fi			(s):/	/	уууу		
Is the Patient under any typ If yes, indicate what assess	e of treatment sment and sind	t / Meds: □YES ce when:	□ NO				
OBJECTIVE / ASSESSME	NT (To be co	ompleted by Phy	sician) Vital Sig	ns T: P:	R: E	3/P:	
Past Medical & Surgical His							
Clinical Details & Description	on of Present (Case:					
Cause: □Physical Illness □Acute	☐ Accident☐ Chronic	☐Maternity ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Preventive ☐Ps ☐Suspected ☐C	sychiatric Dei Other	ntal 🗆 Worl	Related	
Assessment / Diagnosis: INDICATE DIAGNOSIS NOT SYMPTOM					Diagnosis Code		
has 1	occlusion				M26.	1000	
1. class III mal	100 TOSTON						
3.							
Is Assessment / Diagnos related to Diabetes	is related to a	nother Assessm	nent? ☐ YES ☐	NO If yes, spe	cify: (i.e. Re	etinopathy	
MEDICAL PLAN Itemized O	riginal Invoices at	nd Applicable Prescri	otions / Reports / Res	ults must be enclos	ed to conside	r claim	
☐ Consultation		Cost	Cost Physiotherapy			Cost	
Ed obligation			•				
						3	
					تاسىرى	Cost	
☐ Pharmacy		Cost	☐ Laboratory / Radiology / Other				
			Comprehensi	ve orthod	ontic	300	
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TOTAL CHARGES			transfer de la la	and the fact of			
Was In-patient Required? Len	oth of Stav		Indicate Prov	/lder		Cost	
			*				
 Discharge Summary: Item 	ilzed Involces, R	teports & Receipts A	Ittached?		D. Store to	Farala	
Treating Physician Name:	Pratik Pre	mTani	I hereby authoriz or other Organiza	e any Healthcare	Provider, In: nv informatic	surer, Emplo; on regarding	
Name & Address of Facilit		dental dinic	medical condition	n & history to NE	XtCARE for	the purpose	
Tel / Fax: 64 252 99 35			determining insu	rance benefits.			
Email: dentistree der	Ital dinic 1	agmail-com			· ·		
Signature & Stamp.			Patient's Signature	(Parent if minor)	Date		
	Or. Pratik P pecialist Orti		2)				



TAX INVOICE

Reg TRN No

100529934000003

Facility Name

DentisTree Dental Clinic

Address

P.O.Box 23581, Ground floor, Shop 3, Wasl Port Views 8, Al Mina Road, Jumeirah 1, Dubai

042529935 / 045641764

Invoice No

INV-1C008307

Invoice Date

: 21-09-2024

Doctor

Pratik Premjani

Department

: Dental

Patient Name

rraux rrenijani

MRN#

: 3412

raticile (valife

Althea Lorraine Azarcon Sunga 14Y - 7M - 18D / Female

Туре

: Cash

Age / Gender Visit Date

21-09-2024

Inv. Time

: 12:30:52

Si No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	65	ORTHODONTIC MONTHLY VISIT		600.00	1	600.00	300.00	0	0.0000	300.00
Gross	Amount (in AE	(D)								600.00
Discou	int (in AED)									300.00
Net A	mount (in AED)									300.00
Tax or	1 5%(in AED)					<u> </u>				0.00
Total /	Amount(in AEC)								300.00
Paid (i	n AED) (Credit C	ard)			S. W	Janes S				300.00
Baland	ce (in AED)			J. S. Salver	,		\ \$\\\			0.00
Advan	ice Balance (in	AED)		1.7	ì	Ü	1 2 1			0.00

Prepared By Joy

Patient Signature

Kindly note that this automated and uniquely dated invoice is payable on this visit before leaving the Center deposit will be automatically deducted upon settlement.



300.00

RECEIPT VOUCHER (No.REC-1008200)

Date:21-09-2024

Receive from Mr./Mrs./M/s. 3412 - Althea Lorraine Azarcon Sunga

The sum of Dhs. Three Hundred Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 300.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank:

Cheque No.

Date: 21-09-2024

Being

Made by Joy