SAICOHEALTH DAMANA

SAICOHEALTH Medical Claim Form

Section A: To be completed by the insured member	
Patient Details	
SAICOHEALTH Member No.:	Employee No.:
Patient Name: AAYUSH VARDHAN	Date of Birth: 24/10/2001
Email Address:	Mobile Number: 0556363262
Treatment Details	
Country of Treatment:	Date of Treatment: 02/09/2024
Date First Seen:	
Breakdown of Expenses (required)	
Currency of Expenses	aed.
Doctor's Fees (Consultation)	
Medicines	
Others (lab, x-rays, dental, vision, etc.)	
Total Amount Claimed	850
Beneficiary Details	
Pay to (Beneficiary Name):	
IBAN (Mandatory) – If IBAN is not applicable in your country, please provide bank account number:	Bank Name and Branch Details:

Note: Reimbursement claims should be submitted to the Insurer within 90 days from the treatment date if the treatment is availed outside the country of residence, and within 60 days from the treatment date if treatment is availed within the residence country

Authorization: I the undersigned, hereby certify that all answers and all documents submitted with this Claim form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or any information about me and/or any of my family members to provide SAICOHEALTH with the complete information, including copies of their records with reference to any illness, accident, treatment, examination, advice or hospitalization. A photocopy of this authorization shall be taken as the original.

Signature:
Date:

Section B: To be completed by the provider.	
Patient Name (CAPITALS):	Age:
Diagnosis (CAPITALS): K05.00- ACUTE GINGIVITIS, PLAQUE INDUCED K04.01 - REVERSIBLE PULPITIS	ICD:
Type of Treatment: 1) OPG 2) Oral prophylaxis 3) Resin based restoration in #15	
Date of illness (Date first seen: _____)	Accident (Date: _____ Time: _____) (Cause: _____)
Pregnancy (Date of LMP: _____)	Hospitalization: (Date Admitted: _____) (Date Discharged: _____)

PHYSICIAN'S DECLARATION: I certify that the Medical services shown on this form were medically indicated and necessary for the health of the patient.

Physician's Stamp: DENTISTREE Dr. Rutul Desai General Dentist DHA-44339326-001 DENTISTREE DENTAL CLINIC Signature: R. K. Desai Date: 2/9/24

Section C: Attachments Required

- Invoices with proof of payment in the name of the patient
- Doctor's prescription for medicines, lab tests, x-rays, etc.
- Pharmacy invoice clearly showing name of medicine, quantity purchased, and price of each medicine.
- Copy of patient's SAICOHEALTH ID card.
- Medical reports, operative notes, discharge summary, progress reports etc.

Note: Detailed requirements are specified in the claims reimbursement checklist, kindly refer the same for accurate submission

Section D: Contact Information

Email: customerservice@saicohealth.com
Please reference your SAICOHEALTH ID card for local phone number

SAICO Health Care W.L.L.

DENTISTREE DENTAL CLINIC

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-1C008130	**Invoice Date**	:	02-09-2024
Doctor	:	Rutul Desai	**Department**	:	Dental
Patient Name	:	Aayush Vardhan Amit Vardhan	**MRN #**	:	4115
Age / Gender	:	22Y - 10M - 11D / Male	**Type**	:	Cash
Visit Date	:	02-09-2024	**Inv. Time**	:	18:13:55

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D0330	panoramic film		300.00	1	300.00	50.00	0	0.0000	250.00
2	D1110 .	prophylaxis - adult		350.00	1	350.00	100.00	0	0.0000	250.00
3	D2391	resin-based composite - one surface, posterior		365.00	1	365.00	15.00	0	0.0000	350.00

Gross Amount (in AED)	**1,015.00**
Discount (in AED)	**165.00**
Net Amount (in AED)	**850.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**850.00**
Paid (in AED) (Cash)	**850.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**0.00**

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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.

DENTISTREE DENTAL CLINIC

850.00 **RECEIPT VOUCHER (No.REC-1008041)** **Date:04-09-2024**

Receive from Mr./Mrs./M/s. **4115 - Aayush Vardhan Amit Vardhan**

The sum of Dhs. **Eight Hundred Fifty Dirhams and Zero Fils Only**

By Cash **850.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **04-09-2024**

Being

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