Reimbursement Claim Form
Dental

Submit your completed claim form and supporting documents online:
HRDirect > Profile > Remuneration & Benefits > Medical Benefits > Member Portal > Submit Reimbursement claim

Section A - Employee Details

Name of Employee	FABIANO FERNANDES	Staff Number	391313

Section B – Patient Details (To be fully completed by treating dentist)

Patient Name	EVA FERNANDES	DOB	10/12/2012
Complaints / Onset / History			
Diagnosis with tooth number	Class I malocclusion		

Mark the affected tooth with "X" and specify diagnosis details in the above field

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Planned Treatment	Comprehensive orthodontic treatment	
Signature and Stamp	*I declare that I am the patient's treating doctor/dentist and that the particulars given are to the best of my knowledge true and correct* Signature [signature] Date 28/09/24	*Doctor's stamp* DENTISTREE Dr. Pratik Premjani Specialist Orthodontics DHA-00058483-003 DENTISTREE DENTAL CLINIC

Section C – Patient / Spouse / Guardian Signature

I hereby authorise the Emirates Group to obtain any and all medical records, reports and test results, either in original hard-copy form or via access to electronic data systems, as may be required to validate my claim. I consent to the Emirates Group disclosing my medical records, reports and test results for the purpose of processing and validating my claim. In addition, I understand any such medical information provided to the Emirates Group will be accessible to Emirates Group employees (including employees of wholly owned subsidiaries) on the Emirates Medical Benefits System Employee Portal via confidential log-in.

Signature [signature]	Date 28/09/2024

Section D – Employee Checklist

Employee check	Documents Submitted
☑	Claim form
☑	Payment receipts with costs breakdown
☐	Copy of x-ray film (.pdf)
☑	Medical report and prescription
☑	EK referral (for EK Dental Clinic members)

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-1C008360	**Invoice Date**	:	28-09-2024
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Eva Fernandes	**MRN #**	:	3329
Age / Gender	:	11Y - 9M - 18D / Female	**Type**	:	Cash
Visit Date	:	28-09-2024	**Inv. Time**	:	10:15:22

Sl 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	100.00	0	0.0000	500.00

Gross Amount (in AED)	**600.00**
Discount (in AED)	**100.00**
Net Amount (in AED)	**500.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**500.00**
Paid (in AED) (Credit Card)	**500.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**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.

DENTISTREE DENTAL CLINIC

500.00 **RECEIPT VOUCHER (No.REC-1008262)** **Date:28-09-2024**

Receive from Mr./Mrs./M/s. **3329 - Eva Fernandes**

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

By Cash **0.00** / By Credit Card **500.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **28-09-2024**

Being

Made by **Joy**