

REIMBURSEMENT FORM

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

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

ADMINISTRATIVE

Healthcare Provider: <i>Dentistree Dental Clinic</i>	Patient's Name: <i>Ananjan Meghani</i>
Date of Service: <i>10/09/2022</i>	Patient's Tel: <i>0505746756</i>
Emirates ID No: <i>784-198-4105391-5</i>	DOB: <i>10/01/1988</i> Sex: <input type="checkbox"/> F <input checked="" type="checkbox"/> M
Insurance Company:	Email address: (Mandatory)
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) <i>Bleeding gums while brushing</i>
Date of Present Symptom Onset: ___/___/___ <i>dd mm yyyy</i>
What date did the Patient first feel same / similar symptom(s): ___/___/___ <i>dd mm yyyy</i>
Is the Patient under any type of treatment / Meds: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, indicate what assessment and since when:

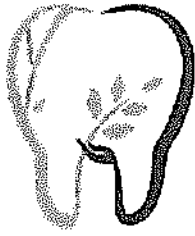
OBJECTIVE / ASSESSMENT (To be completed by Physician) Vital Signs T: P: R: B/P:

Past Medical & Surgical History:	
Clinical Details & Description of Present Case:	
Cause: <input type="checkbox"/> Physical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive <input type="checkbox"/> Psychiatric <input type="checkbox"/> Dental <input type="checkbox"/> Work Related <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input checked="" type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Other	
Assessment / Diagnosis: INDICATE DIAGNOSIS NOT SYMPTOM	Diagnosis Code
1. <i>K05.00 - Acute gingivitis, plaque induced</i>	<i>K05.00</i>
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory / Radiology / Other	Cost
		<i>Oral prophylaxis</i>	<i>350</i>
TOTAL CHARGES			<i>350</i>

Was in-patient Required? Length of Stay _____ Indicate Provider _____ Cost _____	
<p>• Discharge Summary, Itemized Invoices, Reports & Receipts Attached?</p> <p>Treating Physician Name: <i>Dr. Rutul Desai</i> General Dentist</p> <p>Name & Address of Facility: <i>Dentistree Dental Clinic, DHA-44339326-001</i></p> <p>Tel / Fax: _____</p> <p>Email: _____</p> <p>Signature & Stamp: <i>R.K. Desai</i></p>	<p>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.</p> <p>Patient's Signature (Parent if minor) _____ Date _____</p>



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-1C008202 Invoice Date : 10-09-2024
Doctor : Rutul Desai Department : Dental
Patient Name : Dhananjay Meghnani MRN # : 588
Age / Gender : 36Y - 5M - 0D / Male Type : Cash
Visit Date : 10-09-2024 Inv. Time : 17:06:58

SI No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D1110	prophylaxis - adult		350.00	1	350.00	0.00	0	0.0000	350.00
Gross Amount (in AED)										350.00
Discount (in AED)										0.00
Net Amount (in AED)										350.00
Tax on 5%(in AED)										0.00
Total Amount(in AED)										350.00
Paid (in AED) (Cash)										350.00
Balance (in AED)										0.00
Advance Balance (in AED)										0.00

Prepared By Gayle

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

350.00

RECEIPT VOUCHER (No. REC-1008096)

Date: 10-09-2024

Receive from Mr./Mrs./M/s. 588 - Dhananjay Meghnani

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

By Cash 350.00 / By Credit Card 0.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 10-09-2024

Being

Made by Gayle

