Reimbursement
Claim Form

Administrative section

Please keep all original documents and records until your claim is settled. Reimbursements will be processed in the currency your policy has been set-up in. All dependent claim reports will be directed to the contact details provided by the main member. A copy of these reports will also be sent to the main member as per the contact details provided by the Corporate Client. To abide by the Social Distancing Regulations being set by different authorities, all reimbursement requests will be settled by bank transfer only.

Policy number:	Membership number:
Patient name: Madhavan Ranganathan	Provider name: Dentistree Dental Clinic
Date of treatment:	Patient gender: Male
Mobile number:	Email address:

Medical section

Type of visit: ☐ Outpatient ☐ Inpatient ☐ Emergency ☐ Maternity ☑ Dental ☐ Optical

If pregnant, LMP (last menstrual period) date: | Nature of conception:

Chief complaint: Sensitivity

History of present illness (please include duration, date of onset, and when the patient became aware of each condition):

For past 3 days

Clinical findings/other conditions: Dislodged restoration #2

Plaque + + ; stains + +

Past medical history:

Details of trauma - if applicable (when, where and how)

☐ Work related ☐ RTA related (include a police report) ☐ Sports related:

☐ Professional ☐ Non professional

Diagnosis: K08.531 – Fractured dental restorative material with loss of material

K05.10 – Chronic gingivitis, plaque induced

Treatment plan, recommended medications, investigations, and/or procedures:

#2 - composite restoration - 1 surface posterior. ; scaling & polishing (Coadental)

DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6084786
Dubai - U.A.E
DENTISTREE DENTAL CLINIC

Patient declaration

I hereby confirm that I am the patient/AXA card holder, patient's parent or guardian (if under 16 years of age) and I wish to claim and declare that all the details/information given above are to the best of my knowledge true and correct. I hereby consent to and fuly authorise the medical practitioner involved in the patient's care to discuss treatment details and discharge arrangements with and to AXA Insurance (Gulf) B.S.C.(c) representative or any of AXA's affiliates. I subrogate all my rights in relation to this claim and I fully authorise and give access to AXA Insurance (Gulf) B.S.C.(c) representative or any of AXA's affiliates to audit, review, and copy all my medical records details including any historical medical records regardless the previous payer/insurer. I agree that a copy of this consent shall have the validity of the original.

Signature: Date:

Medical practitioner declaration

I declare that I am the patient's medical practitioner, and that the particulars given are to the best of my knowledge true and correct.

Name: Dr. Neha Singh

Date: 19/09/24

nsingh

Signature

DENTISTREE
Dr. Neha Singh
Specialist Endodontics
DHA-00234921-003
DENTISTREE DENTAL CLINIC

Stamp

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Penalties may include but not be restricted to denial of insurance benefits/cover, rendering the insurance contract void and/or legal action to be taken where deemed necessary.

If you have any questions regarding this form or any other aspects of the cover, please contact AXA on UAE +971 (4) 429 4000, Qatar +97 4 412 8733, Bahrain +973 (17) 582 612, Oman +968 800 70292, KSA +966 (1) 478 0282 quoting the policy and membership numbers. Claims must be submitted along with supporting documents within 90 days from date of service or within 180 days for Privilege Members. Send this claim form together with the supporting material to Medical Department, AXA Insurance, P.O. BOX 32505, Dubai, UAE or AXA Insurance, P.O. Box 45, Kingdom of Bahrain, AXA Insurance P.O. Box 1276, P.C. 112, Ruwi, Sultanate of Oman or AXA Insurance P.O. Box 21044, 11475 Riyadh, Kingdom of Saudi Arabia or AXA Insurance, P.O. Box 15319, Doha, State of Qatar.

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-1C008216	**Invoice Date**	:	12-09-2024
Doctor	:	Neha Singh	**Department**	:	Dental
Patient Name	:	Madhavan Ranganathan	**MRN #**	:	3171
Age / Gender	:	54Y - 3M - 18D / Male	**Type**	:	Cash
Visit Date	:	12-09-2024	**Inv. Time**	:	10:58:59

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D1110	prophylaxis - adult		500.00	1	500.00	0.00	0	0.0000	500.00
2	D2391	resin-based composite - one surface, posterior	2	365.00	1	365.00	0.00	0	0.0000	365.00
3	D0330	panoramic film		300.00	1	300.00	0.00	0	0.0000	300.00

Gross Amount (in AED)	**1,165.00**
Discount (in AED)	**0.00**
Net Amount (in AED)	**1,165.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**1165.00**
Paid (in AED) (Bank Transfer)	**1,165.00**
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

1,165.00

RECEIPT VOUCHER (No.REC-1008142)

Date:14-09-2024

Receive from Mr./Mrs./M/s. **3171 - Madhavan Ranganathan**

The sum of Dhs. **One Thousand One Hundred Sixty-Five Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **1,165.00** / By Allocated **0.00**

Bank: Cheque No. Date: **14-09-2024**

Being

Made by **Gayle**

DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6034766
Dubai - U.A.E
DENTISTREE DENTAL CLINIC