NEXtCARE®
Your Health Managed with Care

REIMBURSEMENT FORM

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

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

ADMINISTRATIVE

Healthcare Provider: Dentistree Dental Clinic	Patient's Name: Mitch Lorraine Marion Cirera		
Date of Service: 21/11/21 dd /mm /yyyy	Patient's Tel: 052 - 1471062	DOB 03/02/2010 dd/mm/yyyy	Sex: ☐ F ☐ M
Emirates ID No:		Email address: (Mandatory)	
Insurance Company:			
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)
Date of Present Symptom Onset: _____ / _____ / _____ (dd / mm / yyyy)
What date did the Patient first feel same / similar symptom(s): _____ / _____ / _____ (dd / mm / yyyy)
Is the Patient under any type of treatment / Meds: ☐YES ☐ 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: ☐Physical Illness ☐Accident ☐Maternity ☐Preventive ☐Psychiatric ☐Dental ☐Work Related ☐Acute ☐Chronic ☒Confirmed ☐Suspected ☐Other	
Assessment / Diagnosis: *INDICATE DIAGNOSIS NOT SYMPTOM*	**Diagnosis Code**
1. Class II malocclusion	
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? ☐ YES ☐ 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*

☐ Consultation	Cost	☐ Physiotherapy	Cost
☐ Pharmacy	**Cost**	**☐ Laboratory / Radiology / Other**	**Cost**
		Comprehensive orthodontic treatment	
TOTAL CHARGES			

Was In-patient Required? Length of Stay _____ **Indicate Provider** _____ **Cost** _____

- ***Discharge Summary: Itemized Invoices, Reports & Receipts Attached?***

Treating Physician Name:	*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.*
Name & Address of Facility:	
Tel / Fax:	
Email:	
Signature & Stamp:	*Patient's Signature (Parent if minor)* — *Date*

DENTISTREE DENTAL CLINIC

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-1C008557	**Invoice Date**	:	21-10-2024
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Althea Lorraine Azarcon Sunga	**MRN #**	:	3412
Age / Gender	:	14Y - 8M - 18D / Female	**Type**	:	Cash
Visit Date	:	21-10-2024	**Inv. Time**	:	17:05:13

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	300.00	0	0.0000	300.00

Gross Amount (in AED)	**600.00**
Discount (in AED)	**300.00**
Net Amount (in AED)	**300.00**
Tax on 5%(in AED)	**0.00**
Total Amount(in AED)	**300.00**
Paid (in AED) **(Credit Card)**	**300.00**
Balance (in AED)	**0.00**
Advance Balance (in AED)	**0.00**

عيادة دينتاستري للأسنان
DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6084766
Dubai - U.A.E
DENTISTREE DENTAL CLINIC

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

300.00 **RECEIPT VOUCHER (No.REC-1008477)** **Date:21-10-2024**

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: **21-10-2024**

Being

Made by **Gayle**

DENTISTREE DENTAL CLINIC * عيادة دينتاستري للأسنان *
DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6094765
Dubai - U.A.E

NEOPAY
powered by mashreq

DENTISTREE DENTAL CLINIC
PORT RASHID
DUBAI
POS ID:10131136 MID: 001000110690
DATE: 21/10/24 TIME: 16:53:35
SALE
VISA(Contactless)
443913******4335
EXP: XX/XX
PAN SEQ No : 00
BATCH NO: 755 RECEIPT No :012556
RRN: 001806647076
AMOUNT: AED 300.00
PLEASE DEBIT MY ACCOUNT
NO SIGN REQUIRED FOR CONTACTLESS TXN
APPROVAL CODE: 705599
AID: A0000000031010
LABEL: Visa Debit
TVR: 0000000000 TSI: 0000
AC: F099394650BC2340 CID: 80
THANK YOU
COME AGAIN
<<CUSTOMER COPY>>
APP VERSION:1.80