INCORPORATED IN ABU DHABI IN 1972 WITH PAID UP CAPITAL OF DHS 375,000,000, SUBJECT TO THE PROVISIONS OF THE FEDERAL LAW NO. 6 OF 2007, INSURANCE AUTHORITY REGISTRATION NO. (1)

REIMBURSEMENT MEDICAL CLAIM FORM

Please read the instructions & guidelines on overleaf before filling the form

Voucher No.:

1. Patient's name: Saibani Sahni

2. Patient's Health Card no./Emirates ID no.: 784-1996-7336064-3

3. Group member's name:

4. Reason for not using listed Healthcare facilities: (kindly indicate)

☐ Emergency ☐ Elective ☐ Service not available ☐ On vacation/business trip outside the UAE

☐ Other(s) please specify ....

5. Medical information: (To be filled by treating doctor for all outpatient treatment. For cases like hospitalization procedures and surgeries, a detailed medical report is required)

Condition requiring treatment: Deep decay #16.
K04.7- Periapical abscess without sinus #16.

Visit date: 14-10-24

Onset and duration of illness: Recurrent severe pain in upper left wisdom tooth since 1 month.

Treatment details: D7210 - Surgical extraction of #16.

I declare that I have attended to this patient and that the particulars given are to the best of my knowledge true and correct.

Name & signature of the doctor: Dr. AKSHAYA KULKARNI [signature]

Date: 14/10/2024

Stamp: Dr. Akshaya Kulkarni, Specialist Oral and Maxillofacial Surgery, DHA-00148256-003, DENTISTREE DENTAL CLINIC

6. Name & Address of the Hospital/Clinic	Bill No.	Treatment Date	Description of Services	Amount
Dentistree dental clinic, #3 SHOP BLDG 6	1	14-10-24	Surgical extraction	700 AED
AL WASL PORT VIEWS. AL MINA RD.				
JUM. 1				

Currency (If treatment availed outside the UAE) .... **TOTAL** 700 AED

Stamp: DENTISTREE DENTAL CLINIC, Tel. No.: 04 2522935, Mob. No.: 056 6084766, Dubai - U.A.E.

7. Other information:

Is the above case work-related? ☐ No ☐ Yes (full details) ....

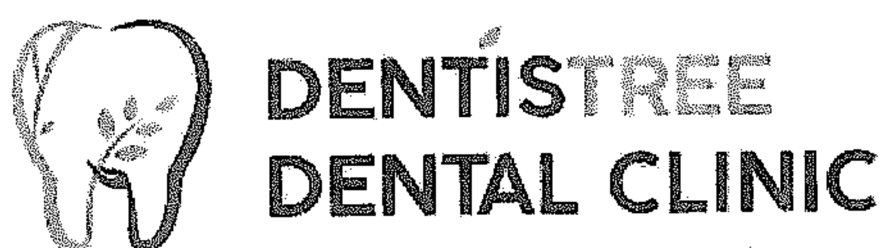
Is the claim covered by another insurance? ☐ No ☐ Yes (pls specify the amount reimbursed and by which insurance company)

8. Declaration:

I, the undersigned, hereby declare that the information above is true and complete and that reimbursement requested is for expenses paid by me for the treatment of my medical condition.

I agree to submit to ADNIC any mandatory/deemed necessary requested document to process my above claim. I hereby authorize ADNIC to approach any doctor/medical facility/any institution or any person who has any record/medical information about me or my family member, to provide ADNIC with complete information including copies of the records when requested.

Name Relationship to the card holder	Signature	Date	Contact no.	Email address



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-1C008491
Doctor : Akshaya Kulkarni
Patient Name : Saibani Sahni
Age / Gender : 28Y - 3M - 25D / Female
Visit Date : 14-10-2024

Invoice Date : 14-10-2024
Department : Dental
MRN # : 4225
Type : Cash
Inv. Time : 11:51:05

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and includin		1,100.00	1	1,100.00	400.00	0	0.0000	700.00

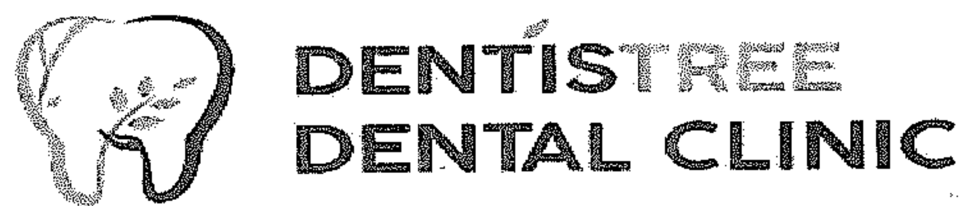
Gross Amount (in AED)	1,100.00
Discount (in AED)	400.00
Net Amount (in AED)	700.00
Tax on 5%(in AED)	0.00
Total Amount(in AED)	700.00
Paid (in AED) (Credit Card)	700.00
Balance (in AED)	0.00
Advance Balance (in AED)	0.00

DENTISTREE DENTAL CLINIC

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.



700.00 **RECEIPT VOUCHER (No.REC-1008409)** **Date:14-10-2024**

Receive from Mr./Mrs./M/s. **4225 - Saibani Sahni**

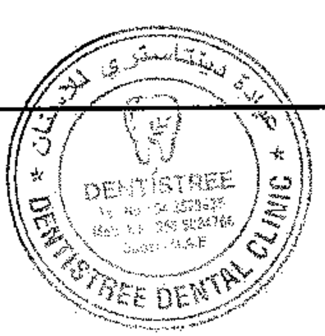
The sum of Dhs. **Seven Hundred Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **700.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **14-10-2024**

Being

Made by **Joy**



DENTISTREE DENTAL CLINIC
PORT RASHID
DUBAI
POS ID:10131136 MID: 001000110690
DATE: 14/10/24 TIME: 11:52:05
SALE
VISA(Contactless)
443138****6288**
EXP: XX/XX
PAN SEQ No : 00
BATCH NO: 748 RECEIPT No :012494
RRN: 001799654847
AMOUNT: AED 700.00
PLEASE DEBIT MY ACCOUNT
NO SIGN REQUIRED FOR CONTACTLESS TXN
APPROVAL CODE: 109882
AID: A0000000031010
LABEL: Visa CREDIT
TVR: 0000000000 TSI: 0000
AC: 5B3A4BA80C56F146 CID: 80
THANK YOU
COME AGAIN
<<CUSTOMER COPY>>
APP VERSION:1.80