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: Ameerah miriam Cheriyan		
Date of Service: dd /mm /yyyy 28/10/2024	Patient's Tel:	DOB dd/mm/yyyy	Sex: ☑ F ☐ M
Emirates ID No: 784-2011-0461941-2		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: 28 (dd) / 10 (mm) / 2024 (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 I 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	500
TOTAL CHARGES			500

DENTISTREE DENTAL CLINIC

Was In-patient Required? Length of Stay ____ **Indicate Provider** ____ **Cost**	
• ***Discharge Summary: Itemized Invoices, Reports & Receipts Attached?***	
Treating Physician Name: Dr. Pratik Premjani	*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: Dentistree Dental Clinic	
Tel / Fax: –	
Email: Dentistreedentalclinic@gmail.com	
Signature & Stamp: Dr. Pratik Premjani Specialist Orthodontics DENTISTREE DHA-00058483-003 DENTISTREE DENTAL CLINIC	*Patient's Signature (Parent if minor)* / *Date*

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-1C008640	**Invoice Date**	:	28-10-2024
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Ameerah Miriam Cheriyan	**MRN #**	:	2661
Age / Gender	:	13Y - 1M - 23D / Female	**Type**	:	Cash
Visit Date	:	28-10-2024	**Inv. Time**	:	17:34:56

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-1008565)

Date:28-10-2024

Receive from Mr./Mrs./M/s. **2661 - Ameerah Miriam Cheriyan**

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: **28-10-2024**

Being

Made by **Joy**

DENTISTREE DENTAL CLINIC