

REIMBURSEMENT FORM

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

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

ADMINISTRATIVE

Healthcare Provider: <u>Dentistree dental clinic</u>	Patient's Name: <u>Ameerah miriam Cheriyan</u>		
Date of Service: <u>dd/mm/yyyy</u> <u>28/10/2024</u>	Patient's Tel:	DOB <u>dd/mm/yyyy</u>	Sex: <input checked="" type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No: <u>784-201-061941-2</u>	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 / 10 / 2024
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: <small>INDICATE DIAGNOSIS NOT SYMPTOM</small>	Diagnosis Code
1. <u>Class I malocclusion</u>	
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

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory / Radiology / Other	Cost
		<u>Comprehensive orthodontic treatment</u>	<u>500</u>

TOTAL CHARGES 500

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

• Discharge Summary: Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name: Dr. Pratik Premjani

Name & Address of Facility: Dentistree Dental Clinic

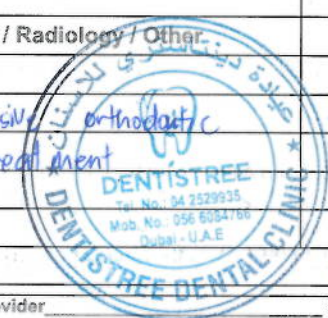
Tel / Fax: _____

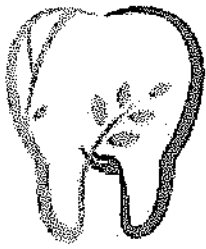
Email: Dentistreedentalclinic@gmail.com

Signature & Stamp: Specialist Orthodontics
DENTISTREE DENTAL CLINIC
DHA-00058483-003

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.

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

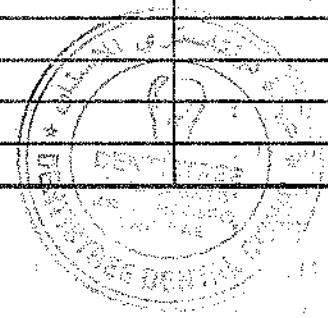
Invoice No : INV-1C008640 Invoice Date : 28-10-2024
Doctor : Pratik Premjani Department : Dental
Patient Name : Ameerah Mirjam Cheriyan MRN # : 2661
Age / Gender : 13Y - 1M - 23D / Female Type : Cash
Visit Date : 28-10-2024 Inv. Time : 17:34:56

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

