

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>Muskaan Noronha</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 type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No: <u>704-2000-4107639-7</u>	Email address: (Mandatory) <u>musnoronh@gmail.com</u>		
Insurance Company:	UAE IBAN Number:		
Account Name:	UAE Swift Code:		

SUBJECTIVE (To be completed by Physician)

Symptom(s) As Described by Patient (CHIEF COMPLAINT)
Date of Present Symptom Onset: <u>28</u> / <u>10</u> / <u>24</u> <u>dd</u> / <u>mm</u> / <u>yyyy</u>
What date did the Patient first feel same / similar symptom(s): <u>28</u> / <u>10</u> / <u>24</u> <u>dd</u> / <u>mm</u> / <u>yyyy</u>
Is the Patient under any type of treatment / Meds: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Physical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Maternity <input type="checkbox"/> Preventive <input type="checkbox"/> Psychiatric <input type="checkbox"/> Dental <input type="checkbox"/> Work Related <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input checked="" type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Other	
Assessment / Diagnosis: <small>INDICATE DIAGNOSIS NOT SYMPTOM</small>	Diagnosis Code
1. <u>Comprehensive orthodontic treatment (CLASS I)</u>	<u>M26.211</u>
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? <input type="checkbox"/> YES <input type="checkbox"/> 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>monthly adjustment</u>	<u>AED 500</u>

TOTAL CHARGES AED 500

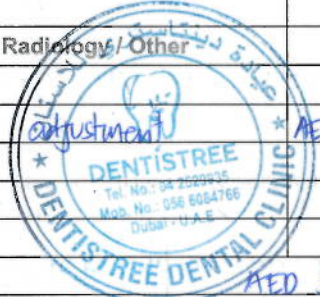
Was In-patient Required? Length of Stay _____ Indicate Provider _____ Cost _____

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

Treating Physician Name: <u>Dr. Pratik Premjani</u>	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: <u>Dentistree dental clinic</u>	
Tel / Fax: _____	

Email: <u>dentistree@dentalclinic.ae@gmail.com</u>	Signature & Stamp	Date
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Dr. Pratik Premjani
Specialist Orthodontics
DENTISTREE DHA-00058483-003





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

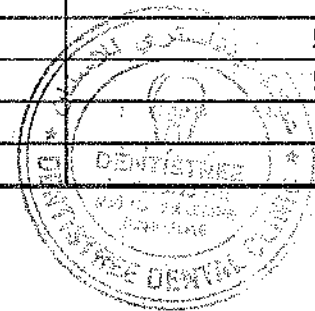
Invoice No : INV-1C008632 Invoice Date : 28-10-2024
Doctor : Pratik Premjani Department : Dental
Patient Name : Muskaan Noronha MRN # : 3907
Age / Gender : 23Y - 11M - 17D / Female Type : Cash
Visit Date : 28-10-2024 Inv. Time : 13:53:27

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-1008555)

Date:28-10-2024

Receive from Mr./Mrs./M/s. **3907 - Muskaan Noronha**

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

