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: Althea Lorraine Azarcon Sunga		
Date of Service: dd /mm /yyyy 06.01.2025	Patient's Tel: 0561871062	DOB dd/mm/yyyy 03/02/2010	Sex: ☑ F ☐ M
Emirates ID No: 784-2010-4780790-0		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: 06 / 01 / 2025 (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 III 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	AED 300
TOTAL CHARGES			

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: 056[illegible]	
Email: dentistreedentalclinic@gmail.com	
Signature & Stamp:	*Patient's Signature (Parent if minor)* / *Date*

Dr. Pratik Premjani Orthodontics 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-1C009337	**Invoice Date**	:	06-01-2025
Doctor	:	Pratik Premjani	**Department**	:	Dental
Patient Name	:	Althea Lorraine Azarcon Sunga	**MRN #**	:	3412
Age / Gender	:	14Y - 11M - 13D / Female	**Type**	:	Cash
Visit Date	:	06-01-2025	**Inv. Time**	:	17:37:02

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**

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

300.00

RECEIPT VOUCHER (No.REC-1009310)

Date:06-01-2025

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: **06-01-2025**

Being

Made by **Joy**