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: Amceran Miriam Cheriyan		
Date of Service: dd /mm /yyyy 05/02/2025	Patient's Tel: 0561517704	**DOB** dd/mm/yyyy 06/09/2011	**Sex:** ☐ F ☑ M
Emirates ID No: 784-2011-6461941-2		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: 05 / 02 / 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 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 ortho dontic treatment	5000
TOTAL CHARGES			

DENTISTREE DENTAL CLINIC
DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6084766
Dubai - U.A.E

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: dentistree Dentalclinic1@gmail.com	
Signature & Stamp: Dr. Pratik Premjani Specialist Orthodontics	*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-1C005507	Invoice Date	:	13-01-2024
Doctor	:	Pratik Premjani	Department	:	Dental
Patient Name	:	Ameerah Miriam Cheriyan	MRN #	:	2661
Age / Gender	:	13Y - 4M - 30D / Female	Type	:	Cash
Visit Date	:	13-01-2024	Inv. Time	:	14:41:08

Sl No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	42	METALLIC BRACES -2 JAWS		12,000.00	1	12,000.00	3,000.00	0	0.0000	9,000.00
2	4	ORTHODONTIC CONSULTATION		400.00	1	400.00	400.00	0	0.0000	0.00
3	D0330	panoramic film		350.00	1	350.00	350.00	0	0.0000	0.00
4	D0340	cephalometric film		350.00	1	350.00	350.00	0	0.0000	0.00
5	63	FIXED RETAINER		1,000.00	1	1,000.00	1,000.00	0	0.0000	0.00

Gross Amount (in AED)	14,100.00
Discount (in AED)	5,100.00
Net Amount (in AED)	9,000.00
Tax on 5%(in AED)	0.00
Total Amount(in AED)	9000.00
Paid (in AED) (Credit Card)	7,000.00
Balance (in AED)	2,000.00
Advance Balance (in AED)	0.00

DENTISTREE DENTAL CLINIC
DENTISTREE
Tel. No.: 04 2529335
Mob. No.: 056 6084766
Dubai - U.A.E

Prepared By Gayle

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-1009718)** **Date:05-02-2025**

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: **05-02-2025**

Being

Made by **Gayle**

DENTISTREE DENTAL CLINIC
DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6084786
Dubai - U.A.E