

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>Amcerah Miriam Chenyan</u>	
Date of Service: - <u>05 / 02 / 2025</u>	Patient's Tel: <u>0561517704</u>	DOB <u>02 / 09 / 2011</u>	Sex: <input type="checkbox"/> F <input checked="" type="checkbox"/> M
Emirates ID No: <u>789 - 2011 - 6961941 - 2</u>		Email address: (Mandatory)	
Insurance Company:			
Account Name:		UAE IBAN Number:	
UAE Bank Name:		UAE Swift Code:	

SUBJECTIVE (To be completed by Physician)

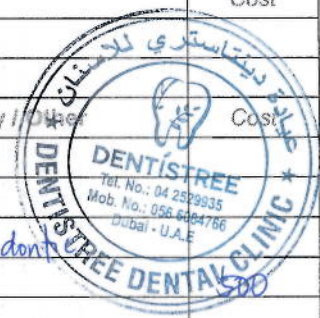
Symptom(s) As Described by Patient (CHIEF COMPLAINT)
Date of Present Symptom Onset: <u>05 / 02 / 2025</u> <small>dd mm yyyy</small>
What date did the Patient first feel same / similar symptom(s): <u> </u> / <u> </u> / <u> </u> <small>dd mm yyyy</small>
Is the Patient under any type of treatment / Meds: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, indicate what assessment and since when:</i>

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>CLASS I Malocclusion</u>	
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, specify: (i.e. Retinopathy related to Diabetes)</i>	

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>			



TOTAL CHARGES

Was In-patient Required? Length of Stay _____	Indicate Provider _____	Cost _____
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• Discharge Summary: Itemized Invoices, Reports & Receipts Attached?

Treating Physician Name: <u>Dr. Pratik Premjani</u>	<i>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.</i>
Name & Address of Facility: <u>Dentistree Dental Clinic</u>	
Tel / Fax:	
Email: <u>dentistree.dentalclinic1@gmail.com</u>	
Signature & Stamp: <u>Dr. Pratik Premjani</u> <small>Specialist Orthodontics</small>	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



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

