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: Rebekah Thomas Gregory		
Date of Service: dd /mm /yyyy 10/01/2025	Patient's Tel: 055 9915608	DOB dd/mm/yyyy 26/12/2006	Sex: ☐F ☐M
Emirates ID No: 784-2006-9436920-6		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: 09 / 01 / 25 (dd / mm / yyyy)
What date did the Patient first feel same / similar symptom(s): 22 / 12 / 24 (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. Caries pit & fissure	K02.52
2. Gingivitis Plaque induced	K05.10
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
D2391 Tooth no 30 (O)	430		
D2391 Tooth no 31 (O)	430		
☐ Pharmacy D2391 Tooth no 2 (O)	430	☐ Laboratory / Radiology / Other	Cost
D2391 Tooth no 3 (O)	430		
D2391 Tooth no 15 (O)	430		
D2391 Tooth no A (B)	430		
D2391 Tooth no 18 (O)	430		
D1110 Prophylaxis	350		
TOTAL CHARGES AED 3,360			

Was In-patient Required? Length of Stay_____ Indicate Provider_____ Cost

- *Discharge Summary: Itemized Invoices, Reports & Receipts Attached?*

Treating Physician Name: Dr. Aliasgar Taskin Name & Address of Facility: General Dentist Tel / Fax: DENTISTREE DHA-37216563 Email: DENTISTREE DENTAL CLINIC	*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.* Rebecca S.
Signature & Stamp:	*Patient's Signature (Parent if minor)* / *Date*