

REIMBURSEMENT FORM

24 hour Tel: 04-2708800, Fax: 04 2708592

Please Complete Clearly (All Fields Mandatory) FORM No:

ADMINISTRATIVE

Healthcare Provider: <i>DENTISTREE Dental Clinic</i>	Patient's Name: Argun Nupur Agarwani		
Date of Service: 22/02/2025	Patient's Tel: 0507916756	DOB dd/mm/yyyy	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No:	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) Periorbital fluoride application			
Date of Present Symptom Onset: 22 / 02 / 2025			
What date did the Patient first feel same / similar symptom(s): 22 / 02 / 2025			

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. Encounter of prophylactic fluoride administration.		Z29.3
2.		
3.		

Is Assessment / Diagnosis related to another Assessment? YES NO If yes, specify: (i.e. Retinopathy related to Diabetes)

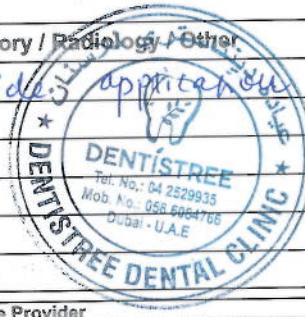
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim

<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory / Radiology / Other	Cost
		Fluoride application	100/-
TOTAL CHARGES			

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

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

Treating Physician Name: Dr. Rutul Desai		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:			
Tel / Fax:		Dr. Rutul Desai General Dentist	
Email:	DENTISTREE DHA-44339326-001		
Signature & Stamp:	DENTISTREE DENTAL CLINIC		
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-1C009884	Invoice Date	22-02-2025
Doctor	Rutul Desai	Department	Dental
Patient Name	Arjun Nupur Meghnani	MRN #	4827
Age / Gender	3Y - 8M - 21D / Male	Type	Cash
Visit Date	22-02-2025	Inv. Time	14:42:18

SI No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	D1203	topical application of fluoride - child		100.00	1	100.00	0.00	0	0.0000	100.00
Gross Amount (in AED)										100.00
Discount (in AED)										0.00
Net Amount (in AED)										100.00
Tax on 5%(in AED)										0.00
Total Amount(in AED)										100.00
Paid (in AED) (Credit Card)										100.00
Balance (in AED)										0.00
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

100.00

RECEIPT VOUCHER (No.REC-1009910)

Date:22-02-2025

Receive from Mr./Mrs./M/s. 4827 - Arjun Nupur Meghnani

The sum of Dhs. One Hundred Dirhams and Zero Fils Only

By Cash 0.00 / By Credit Card 100.00 / By Cheque 0.00 / By Bank Transfer 0.00 / By Allocated 0.00

Bank: Cheque No.

Date: 22-02-2025

Being

Made by Gayle

