[redacted]

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: Arpan Nupur Meghani		
Date of Service: 22/02/2025 dd /mm /yyyy	Patient's Tel: 0557467756	**DOB** dd/mm/yyyy	**Sex:** ☐ F ☐ 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) Precautionary flouride application.

Date of Present Symptom Onset: 22 / 02 / 2025 (dd / mm / yyyy)

What date did the Patient first feel same / similar symptom(s): 22 / 02 / 2025 (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. Encounter of prophylactic flouride 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*

☐ **Consultation**	*Cost*	☐ **Physiotherapy**	*Cost*
☐ **Pharmacy**	*Cost*	☐ **Laboratory / Radiology / Other**	*Cost*
		Flouride 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

Name & Address of Facility:

Tel / Fax:

Email:

Signature & Stamp:

DENTISTREE DENTAL CLINIC
Dr. Rutul Desai
General Dentist
DHA-44339326-001

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.

Patient's Signature (Parent if minor) | *Date*

DENTISTREE DENTAL CLINIC
DENTISTREE
Tel. No.: 04 2529935
Mob. No.: 056 6064766
Dubai - U.A.E

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

Sl 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**

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

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**

DENTISTREE
Tel. No.: 04 2523935
Mob. No.: 056 6084766
Dubai - U.A.E
DENTISTREE DENTAL CLINIC