

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: <i>Arjun Nupur Achhanni</i>		
Date of Service: <i>22/02/2025</i> dd/mm/yyyy	Patient's Tel: <i>05746756</i>	DOB dd/mm/yyyy	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Emirates ID No:		Email address: (Mandatory)	
Insurance Company:		UAE IBAN Number:	
Account Name:		UAE Swift Code:	
UAE Bank Name:			

SUBJECTIVE (To be completed by Physician)

Symptom(s) As Described by Patient (CHIEF COMPLAINT) <i>Peri-auricular fluoride application</i>	
Date of Present Symptom Onset: <i>22 / 02 / 2025</i> dd mm yyyy	
What date did the Patient first feel same / similar symptom(s): <i>22 / 02 / 2025</i> dd mm yyyy	
Is the Patient under any type of treatment / Meds: <input type="checkbox"/> YES <input type="checkbox"/> 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: <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: <i>INDICATE DIAGNOSIS NOT SYMPTOM</i>	Diagnosis Code
1. <i>Encounter of prophylactic fluoride administration</i>	<i>Z29.3</i>
2.	
3.	
Is Assessment / Diagnosis related to another Assessment? <input type="checkbox"/> YES <input type="checkbox"/> 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

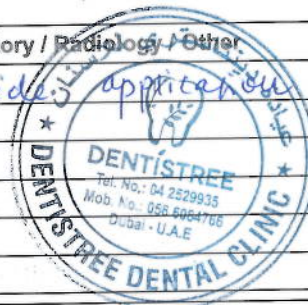
<input type="checkbox"/> Consultation	Cost	<input type="checkbox"/> Physiotherapy	Cost
<input type="checkbox"/> Pharmacy	Cost	<input type="checkbox"/> Laboratory / Radiology / Other	Cost
		<i>Fluoride application</i>	<i>100/-</i>

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: <i>Dr. Rutul Desai</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.	
Name & Address of Facility:		
Tel / Fax:		
Email:		
Signature & Stamp: <i>Dr. Rutul Desai</i> <i>DENTISTREE DENTAL CLINIC</i>	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

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



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/س. 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**

