

# Reimbursement Claim Form

## Dental



Submit your completed claim form and supporting documents online:  
HRDirect > Profile > Remuneration & Benefits > Medical Benefits > Member Portal > Submit Reimbursement claim

### Section A - Employee Details

Name of Employee

Staff Number

### Section B - Patient Details (To be fully completed by treating dentist)

Patient Name

EVA FERNANDES

DOB

10.12.2012

Complaints /  
Onset / History

Diagnosis with tooth  
number

CLASS I MALOCCLUSION WITH CROWDING

Mark the affected tooth with "X" and specify diagnosis details in the above field

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Planned Treatment

COMPREHENSIVE ORTHODONTIC TREATMENT

Signature and Stamp

I declare that I am the patient's treating doctor/dentist and that the particulars given are to the best of my knowledge true and correct

Signature

Date



### Section C - Patient / Spouse / Guardian Signature

I hereby authorise the Emirates Group to obtain any and all medical records, reports and test results, either in original hard-copy form or via access to electronic data systems, as may be required to validate my claim. I consent to the Emirates Group disclosing my medical records, reports and test results for the purpose of processing and validating my claim. In addition, I understand any such medical information provided to the Emirates Group will be accessible to Emirates Group employees (including employees of wholly owned subsidiaries) on the Emirates Medical Benefits System Employee Portal via confidential log-in.

Signature

Date / /

### Section D - Employee Checklist

Employee check	Documents Submitted
<input type="checkbox"/>	Claim form
<input checked="" type="checkbox"/>	Payment receipts with costs breakdown
<input type="checkbox"/>	Copy of x-ray film (.pdf)
<input type="checkbox"/>	Medical report and prescription
<input type="checkbox"/>	EK referral (for EK Dental Clinic members)



# 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-1C009874	Invoice Date	: 21-02-2025
Doctor	: Pratik Premjani	Department	: Dental
Patient Name	: Eva Fernandes	MRN #	: 3329
Age / Gender	: 12Y - 2M - 12D / Female	Type	: Cash
Visit Date	: 21-02-2025	Inv. Time	: 16:23:23

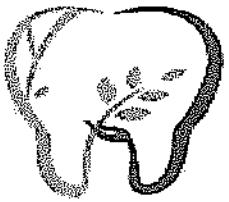
SI No	Service Code	Treatment / Procedure	Tooth No	Unit Price	Qty	Gross	Discount	VAT %	VAT Amount	Net
1	65	ORTHODONTIC MONTHLY VISIT		600.00	1	600.00	100.00	0	0.0000	500.00
<b>Gross Amount (in AED)</b>										<b>600.00</b>
<b>Discount (in AED)</b>										<b>100.00</b>
<b>Net Amount (in AED)</b>										<b>500.00</b>
<b>Tax on 5%(in AED)</b>										<b>0.00</b>
<b>Total Amount(in AED)</b>										<b>500.00</b>
<b>Paid (in AED) (Bank Transfer)</b>										<b>500.00</b>
<b>Balance (in AED)</b>										<b>0.00</b>
<b>Advance Balance (in AED)</b>										<b>0.00</b>

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-1009899)

Date:21-02-2025

Receive from Mr./Mrs./M/s. 3329 - Eva Fernandes

The sum of Dhs. **Five Hundred Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **0.00** / By Cheque **0.00** / By Bank Transfer **500.00** / By Allocated **0.00**

Bank: Cheque No.

Date: **21-02-2025**

Being via **paymob**

Made by **Gayle**

