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: Payal Dudhani		
Date of Service: 25/02/2025 dd /mm /yyyy	Patient's Tel: 055 - 4126911	DOB 11/12/1986 dd/mm/yyyy	Sex: ☑ F ☐ M
Emirates ID No: 784-1986-0382054-3		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: _____ / _____ / _____ dd mm yyyy
What date did the Patient first feel same / similar symptom(s): _____ / _____ / _____ 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. Fracture of tooth with infection	K04.7
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
		Surgical extraction	
			1200
		of tooth #12	
TOTAL CHARGES			

DENTISTREE DENTAL CLINIC
DENTISTREE Tel. No.: 04 2329935 Mob. No.: 056 6084766 Dubai - U.A.E

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

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

Treating Physician Name:	*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: Dr. Shyam Bhat Specialist Oral & Maxillofacial Surgery DHA-00212475-005 DENTISTREE DENTAL CLINIC	
Tel / Fax:	
Email:	
Signature & Stamp:	*Patient's Signature (Parent if minor)* / *Date*