REIMBURSEMENT FORM

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

Please Complete Clearly *(All fields are mandatory)*

ADMINISTRATIVE

Healthcare Provider:	Patient's Name:		
Date of Service: dd /mm /yyyy	Patient's Tel:	**DOB** dd/mm/yyyy	**Sex: ☐F ☐M**
Emirates ID No:		Email address:	
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.	
2.	

Is Assessment / Diagnosis related to another Assessment? ☐YES ☐NO *If yes, specify: (i.e. Retinopathyrelated **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*
TOTAL CHARGES			

Was In-patient Required? Length of Stay_____**Indicate Provider Cost**

Discharge Summary: Itemized Invoices, Reports & Receipts

Treating Physician Name:	*I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding mymedical condition & history to NEXtCARE for the purpose of determining insurance benefits.*	
Name & Address of Facility:		
Tel / Fax:		
Email:		
Signature & Stamp:	*Patient's Signature (Parent if minor)*	*Date*

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