REIMBURSEMENT FORM

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

Please Complete Clearly (All Fields Mandatory)

ADMINISTRATIVE **FORM No:**

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: (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.	
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*
TOTAL CHARGES			

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:		
Tel / Fax:		
Email:		
Signature & Stamp:	*Patient's Signature (Parent if minor)*	*Date*