NEXtCARE®
Your Health Managed with Care

REIMBURSEMENT FORM

24 hour Tel: +974 4 4341057, Fax: +974 4 4231100

Please Complete Clearly (All Fields Mandatory) **FORM No:**

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: (Mandatory)	
Insurance Company:			
Account Name:	QATAR IBAN Number:		
QATAR Bank Name:	QATAR 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*