

Reimbursement Form

Please fill the form Clearly
(All Fields Mandatory)

Medical Provider:	Patient's Name:		
Date of Treatment:	Patient's Tel:	DOB:	Sex: F <input type="checkbox"/> M <input type="checkbox"/>
Emirates ID No:	Email address:		
Bank Details:			
Name:	UAE IBAN:		
Bank Name:			

(To be completed by Physician)

Symptom(s) As Described by Patient (MAIN COMPLAINT)

Date of Present Symptom Onset: 15 / 12 / 2025

What date did the Patient first feel same / similar symptom(s): _____ / _____ / _____

Is the Patient under any type of treatment / Meds: YES ☒ NO ☐
If yes, indicate what assessment and since when:

*Klavox 625mg
1+3 (5day)*

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

1. *acute pulpitis 81*

2.

3.

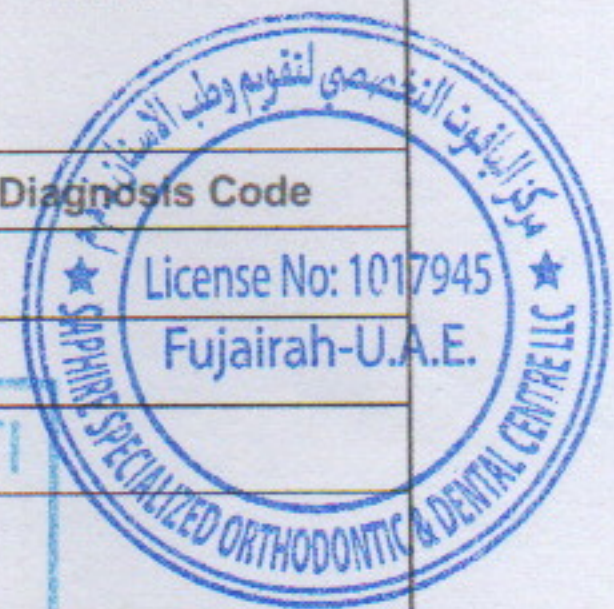
Al Bayati

Diagnosis Code

License No: 1017945
Fujairah-U.A.E.

Is Assessment / Diagnosis related to another Assessment? YES ☐ NO ☒

DR. HALA GHAZI ALBAYATI
 License No.: D37505
 G.P. DENTIST



Documents Required:

- **Inside UAE:** 1. Itemized Invoices. 2. Applicable Prescriptions. 3. Receipt/proof of payment 4. Diagnostic investigation Results. 5. Discharge Summary and OT notes (Inpatient).
- **Outside UAE:** same as 1 in Arabic or English/ translated to English.
- **Physiotherapy:** Referral from Orthopedic or Neurologist
- **Speech Therapy:** Referral from treating doctor

Treating Physician Name:	<i>Dr. Hala Ghazi Al Bayati</i>
Name & Address of Facility:	<i>Sapphire Specialized Dental Center</i>
Tel:	<i>092223939</i>
Email:	
Signature & Stamp:	
I hereby authorize any Healthcare Provider, Insurer, Employer or other Organization to release any information regarding my medical condition & history to ABNIC for the purpose of determining insurance benefits.	
Patient's Signature (Parent if minor)	Date



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