شركة البحيرة الوطنية للتأمين
Al-Buhaira National Insurance Co.

Reimbursement Form

Please fill the form Clearly
(All Fields Mandatory)

Medical Provider:	**Patient's Name:**		
Date of Treatment:	**Patient's Tel:**	**DOB:**	**Sex: F ☐ M ☐**
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 ☐ Klavox 625 mg 1+3 (5 days)
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. acute pulpitis 81	
2.	
3.	

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

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

مركز البيانات التخصصي لتقويم وطب الأسنان
SAPHIRE SPECIALIZED ORTHODONTIC & DENTAL CENTRE LLC
License No: 1017945
Fujairah-U.A.E.

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 I in Arabic or English/ translated to English.
- **Physiotherapy:** Referral from Orthopedic or Neurologist
- **Speech Therapy:** Referral from treating doctor

Treating Physician Name:	Dr. Hala Ghazi Al Bayati
Name & Address of Facility:	Sapphire Specialized Dental Center
Tel:	092223939
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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