REIMBURSEMENT FORM

To contact us, visit www.nextcarehealth.com/contact-us

Please complete the below form clearly *(All fields are mandatory)*

ADMINISTRATIVE

Healthcare Provider:		Patient's Name:	
Date of Service: dd/mm/yyyy	Patient's Tel:	Date of Birth: dd/mm/yyyy	Sex: ☐ F ☐ M
National ID/Insurance Card No:		Email Address:	
Insurance Company:			
Account Name:		IBAN Number:	
Bank Name:		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 / medication: ☐ 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 the diagnosis, not symptoms)*	**Diagnosis Code**
1.	
2.	
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		
Treating Physician Name:	***Declaration of Medical Information Release:*** *I hereby give Nextcare my consent, to process, share, and transfer my Confidential Information (including Personal & Health data) to Nextcare entities, branches and affiliates, business partners, professional advisers, and/or service providers, where Nextcare believes that the transfer or share, of such personal data is necessary for: (i) the performance of the Policy; (ii) assisting in the development of the business and products; (iii) improving Nextcare customer's experience; (iv) compliance with the applicable laws and regulations; or (v) compliance with other law enforcement agencies for international sanctions and other regulations applicable to Nextcare.*	
Name & Address of Facility:		
Tel / Fax:		
Email:		
Signature & Stamp:	Patient's Signature *(Parent if minor)*	Date