**Nextcare Dental Reimbursement Form**

**Patient Information:**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Details:**

* **Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Clinic/Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Treatment Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Amount Paid: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reimbursement Request:**

* **Reason for Reimbursement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Type of Expense (Check one):
☐ Dental Procedure
☐ Consultation Fee
☐ Prescription
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment Details:**

* **Preferred Reimbursement Method (Check one):
☐ Direct Deposit
☐ Check**
* **Bank Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Routing Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attachments:**

* **☐ Original Receipt**
* **☐ Doctor’s Letter (if required)**
* **☐ Insurance Card Copy**

**Declaration:
I certify that the above information is true and that I am requesting reimbursement for a valid expense under my insurance policy.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**