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: _____