**Nextcare Reimbursement Form Template**

**Policyholder Details:**

* **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Insurance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Claim Information:**

* **Service Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Treatment Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Total Expense: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reimbursement Selection:**

* **☐ Full Amount**
* **☐ Partial Amount (Specify: $\_\_\_\_\_\_\_\_\_\_)**

**Supporting Documents (Check all that apply):**

* **☐ Invoice**
* **☐ Payment Proof**
* **☐ Prescription**

**Signature & Approval:**

* **Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Reviewed by (Office Use Only): \_\_\_\_\_\_\_\_\_\_\_\_\_**