**Orient Nextcare Reimbursement Form**

**Member Details:**

* **Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Service Details:**

* **Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Type of Service (Check One):
☐ Consultation
☐ Lab Tests
☐ Medication
☐ Surgery**

**Expense Breakdown:**

| **Service** | **Amount Paid** | **Approved Amount** | **Balance Due** |
| --- | --- | --- | --- |
|  | **$\_\_\_\_\_\_\_\_** | **$\_\_\_\_\_\_\_\_** | **$\_\_\_\_\_\_\_\_** |
|  | **$\_\_\_\_\_\_\_\_** | **$\_\_\_\_\_\_\_\_** | **$\_\_\_\_\_\_\_\_** |

**Declaration & Submission:
I confirm that the details provided are accurate, and I have attached the necessary documents for reimbursement processing.**

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