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: _____