Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : MOHAMMAD SAMEER	Membership Number from your card : 52SC5172
	Date of Birth : 04-Aug-1983
	Tel Number : 0566599085
	Fax Number : Resident

Section B - Medical Section(To be fully completed by treating physician or dentist - all boxes must be completed in block capitals)

Condition/s requiring treatment:

Presenting Complaints:

For follow up,

Complaining of movement and crawling sensation all over his head.

He is known to have major depression and currently being managed by the psychiatrist but has not been on medications for week.

Report also shows hypercholesterolemia for which he was previously taking atorzet but stopped over a month ago.

Counselled to go see the psychiatrist and re-commence medication.

History:

Clinical Findings:

How long has the patient been aware of the complaint/s?:

Date first consultation with any practitioner for this/these condition/s?:

Planned treatment and prognosis

CPT Code	Treatment	Type
9.01	Free Follow-Up Consultation Of The Same Diagnosis Within 7 Days Of Initial Consultation By A General Practitioner.	General Consulta

Section C - Treating Physician/Dentist

I declare that i am the patient's treating Physician/Dentist, and that the particulars given are to the best of my knowledge true and correct	Tel Number : 12345(
	Fax Number : GP008
Signature	Medical Practitioner's

Dr. Enomen Goodluck E
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER
DUBAI - U.A.E.

Date :

Other Insurer's details(If the treatment is accident-related or covered under another insurance policy please provide details)

Insurance Company Name : NEURON - RN RN1	Policy Number :

Patient's Declaration and Consent

I conform that i am the patient (or the patient's parent or guardian if the patient is under 16 years of age)and declare that all t given above are ture. I hereby consent to and authorise the medical provider, health professional or other relevant medical est provide and discuss any health/treatment details, medical records or discharge arrangements (past and present) with and to th /or Third Party Administrator. I agree that a copy of this consent shall have the validity of the original.

Signature

Date :

The Claim form should be submitted within 90 days of start date of the treatment along with all original receipts/invoices as per the policy membership agreement. All appeals and queries regarding the claim should be submitted within 180 days of treatment. Claims will not be considered if not submitted within 90 days of treatment being received. Send this claim form together with supporting material to:**Medical Claims Department, Neuron LLC P O Box 72071, Dubai, UAE**

Claim Number(Neuro