Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : JOY REY ELICOT	Membership Number from your card : 52SC4878(
	Date of Birth : 27-Sep-1994
	Tel Number : 0524478234
	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:

PC: COUGH

ASTHMATIC KNOWN

ANAL FISSURE

LOW BACK PAIN

FUNGAL INFECTION

MIGRAINE

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
86140	C-Reactive Protein	Lab
85025	Blood Count Complete Auto&Auto Difrntl Wbc Count	Lab
9	Consultation Gp	General Consultation

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 : 05216
	Fax Number :
Signature	Medical Practitioner's

Dr. Ahsan Hussain
General Practitioner
DHA No: 87543658-001
CITICARE MEDICAL CENTER L
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