Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : ABDUL GAFOOR THAYYIL	Membership Number from your card : 52SC95166812795
	Date of Birth : 02-Jul-1979
	Tel Number : 050887664
	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:

Recurrent coughing and chest pain.

Duration: 3days

Breathless started this afternoon and also fever.

Had one episode of vomiting.

Known asthmatic and hypertensive.

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	Consultation Gp	General Consultation
80061	Lipid Panel	Lab
86140	C-Reactive Protein	Lab
85025	Blood Count Complete Auto&Auto Difrntl Wbc Count	Lab
0006-402803-2071	VENTOLIN NEBULES	Pharmacy
0188-135906-2441	PULMICORT	Pharmacy
94640	Pressurized/Nonpressurized Inhalation Treatment	Co.Pay

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 : 1234567
	Fax Number : GP008
Signature  Date :	Medical Practitioner's Stamp: Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.

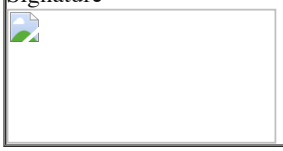
Other Insurer's details(If the treatment is accident-related or covered under another insurance policy please provide details)

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 the particulars given above are ture. I hereby consent to and authorise the medical provider, health professional or other relevant medical establishment to provide and discuss any health/treatment details, medical records or discharge arrangements (past and present) with and to the insurer and /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(Neuron use only)