Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : MAHESH CHAMINDA GUNASEKARA	Membership Number from your card : 681034202
	Date of Birth : 11-May-1981
	Tel Number : 0555123109
	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: Upper abdominal pain, nausea, dizziness, but has not vomited

Duration: today

There is no fever,

Known hyperensive and diabetic on routine maintenance medications.

History:

Clinical Findings: **K29.00 - Acute gastritis without bleeding, K21.9 - Gastro-esophageal reflux disease without esophagitis, E78 hyperlipidemia, E11.8 - Type 2 diabetes mellitus with unspecified complications, I10 - Essential (primary) hypertension, M10. unspecified**

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
86677	Antibody Helicobacter Pylori	Lab
82947	Glucose Quantitative Blood Xcpt Reagent Strip	Lab
80061	Lipid Panel	Lab
85025	Blood Count Complete Auto&Auto Difrntl Wbc Count	Lab

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 :

Claim Number(Neurc

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**