# Neuron Direct Billing Claim Form - General

**Section A - Details of Member/Patient**

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|---|---|
| Patient's Name and Address : USMAN RIAZ | Membership Number from your card : 52SC09117312177 |
| | Date of Birth : 20-Jul-1990 |
| | Tel Number : 0565518726 |
| | 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: FEVER**

**COUGH**

**BRONCHITIS**

**LYMPH NODE SWELLING**

History:

Clinical Findings: **S80.221A - Blister (nonthermal), right knee, initial encounter, R50.9 - Fever, unspecified, L04.0 - Acute lymphadenitis of face, head and neck, R05 - Cough, J20.9 - Acute bronchitis, 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 |
|---|---|---|
| 9.01 | Free Follow-Up Consultation Of The Same Diagnosis Within 7 Days Of Initial Consultation By A General Practitioner. | General Consultation |
| 96372 | Therapeutic Prophylactic/Dx Injection Subq/Im | Co.Pay |
| 0125-122107-1022 | DEXAMETHASONE SODIUM PHOSPHATE | Pharmacy |
| 51.02 | Non-Surgical Cleansing With Surgical Dressing Between 16 Sq Inches / 100 Sq Centimeters And 48 Sq Inches / 300 Sq Centimeters | General Consultation |
| 96365 | Iv Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr | Co.Pay |
| 0195-107704-0801 | CEFTRIAXONE-TABUK IV | Pharmacy |

**Section C - Treating Physician/Dentist**

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| 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 : 0521644729 |
| | Fax Number : |
| Signature  Date : | Medical Practitioner's Stamp:   |

**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**

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| 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**

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| Claim Number(Neuron use only) |