Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : MOHAMMAD SAMEER	Membership Number from your card : 52SC51725504235
	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:

PC: Cough, fever, nasal congestion, runny nose.

Duration: 1day.

History:

Clinical Findings: **J20.9 - Acute bronchitis, unspecified, J30.9 - Allergic rhinitis, unspecified, K21.9 - Gastro-esophageal reflux disease without esophagitis, J01.00 - Acute maxillary sinusitis, 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
96375	Therapeutic Injection Iv Push Each New Drug	Co.Pay
96374	Ther Proph/Dx Njx Iv Push Single/1St Sbst/Drug	Co.Pay
96372	Therapeutic Prophylactic/Dx Injection Subq/Im	Co.Pay
9	Consultation Gp	General Consultation
0005-111805-1021	CHLOROHISTOL 10MG	Pharmacy
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy
0005-149902-1021	CLOFEN	Pharmacy

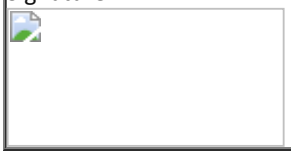
Section C - Treating Physician/Dentist

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)