



Neuron Direct Billing Claim Form - General



Section A - Details of Member/Patient

Patient's Name and Address : UMME ROOMAN ABU BILAL MOHAMMAD AKRAM	Membership Number from your card : 52GM1975421839701
	Date of Birth : 15-Mar-1999
	Tel Number : 0563567206
	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:		
History:		
Clinical Findings: N39.0 - Urinary tract infection, site not specified, J20.9 - Acute bronchitis, unspecified, J30.9 - Allergic rhinitis, unspecified, R50.9 - Fever, unspecified, M79.10 - Myalgia, unspecified site		
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
96361	Iv Infusion Hydration Each Additional Hour	Co.Pay
96365	Iv Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr	Co.Pay
96375	Therapeutic Injection Iv Push Each New Drug	Co.Pay
96372	Therapeutic Prophylactic/Dx Injection Subq/Im	Co.Pay
9	Consultation Gp	General Consultation
0102-111908-1001	SODIUM CHLORIDE B.P.	Pharmacy
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION	Pharmacy
0005-149902-1021	CLOFEN	Pharmacy
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy
76705	Ultrasound Abdominal Real Time W/Image Limited	Radiology
87088	Culture Bct Isol&Prsmptv Id Isolate Ea Urine	Lab
81001	Urnl Dip Stick/Tablet Reagent Auto Microscopy	Lab
86140	C-Reactive Protein	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 : 1234567
	Fax Number : GP008

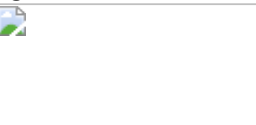
Signature  Date :	Medical Practitioner's Stamp: Dr. Enomen Goodluck Ekata General Practitioner DHA No: 28040827-001 CITICARE MEDICAL CENTER LLC DUBAI - U.A.E.
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Other Insurer's details(If the treatment is accident-related or covered under another insurance policy please provide details)

Insurance Company Name : NEURON - CN GN+ GNP	Policy Number :
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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 :
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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)

