Neuron Direct Billing Claim Form - General

Section A - Details of Member/Patient

Patient's Name and Address : HANA KUWATA	Membership Number from your card : 52SC06642668952
	Date of Birth : 18-May-1994
	Tel Number : 0509878710
	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:

co fever headache throat pain dry cough 4th dec. 2024

oe chest is congested no added sounds

restless

History:

Clinical Findings: **J06.9 - Acute upper respiratory infection, unspecified, R50.9 - Fever, unspecified, R05 - Cough, J30.9 - Allergic rhinitis, unspecified, K29.00 - Acute gastritis without bleeding**

How long has the patient been aware of the complaint/s?:

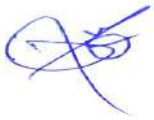
Date first consultation with any practitioner for this/these condition/s?:

Planned treatment and prognosis

CPT Code	Treatment	Type
96368	Iv Nfs Therapy Prophylaxis/Dx Concurrent Nfs	Co.Pay
96372	Therapeutic Prophylactic/Dx Injection Subq/Im	Co.Pay
94640	Pressurized/Nonpressurized Inhalation Treatment	Co.Pay
0188-135906-2441	PULMICORT	Pharmacy
0005-174202-0781	RISEK 40MG	Pharmacy
0125-122107-1022	DEXAMETHASONE SODIUM PHOSPHATE	Pharmacy
2190-106618-1001	PARAFUSIV I.V. 10MG/ML	Pharmacy
96365	Iv Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr	Co.Pay
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy
9.01	Free Follow-Up Consultation Of The Same Diagnosis Within 7 Days Of Initial Consultation By A General Practitioner.	General Consultation

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 : 0521644729
	Fax Number :

Signature  Date :	Medical Practitioner's Stamp: 

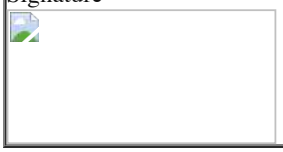
Other Insurer's details(If the treatment is accident-related or covered under another insurance policy please provide details)

Insurance Company Name : NEURON - RN RN1	Policy Number :

Patient's Declaration and Consent

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)