
Patient 38722 JIREH CALEB PARAN MERCADO 784-2020-6586381-7 Repeat 5 Male Philippine S NEURON - CN GN GNP - CIGNA INSURANCE MIDDLE EAST (S.A.L) - DUBAI BRANCH - Default Scheme (99999) Medical History (patient_history.aspx?patId=39747) Billing History (patient_accounts.aspx?patId=39747)

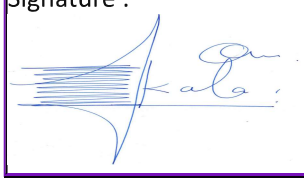
Appointment Visit ID 56841 09-Jan-2025 Enomen Goodluck - General - DHA-P-28040827 MRN Activities(Log) Insurance Cards EMID Card

Vitals Alert This Patient has Vitals for Temp: 38°C, Pulse: 100bpm, BP: 0mmHg, Height: 111cm, Weight: 17.7kg, BMI 14.37(Obese), Blood Sugar

Start Time | Nurse Station | Doctor Evaluation | Orthopedic Case Assessment | Diagnosis | Treatments/Procedures | Packages | Prescription | Reimbursement Forms | Documents | Progress Notes | Addendum | NEURON General FORM | NEURON Reimb. FORM | Other Forms | Sick Leave | End Time | Visit Summary Sheet | Nabidh Clinical Docs | Audit Log | Radiology | Laboratory | Health Declaration | Signed Documents | Image Comparison

| | | |
|---|---|---|
| 94640 | Pressurized/Nonpressurized Inhalation Treatment | Co.Pay |
| | | |

**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 : 12 |
| | Fax Number : GF |
| Signature :  Date : 09-01-2025 | Medical Practitio   |

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

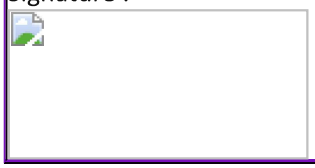
| | |
|---|---|
| Insurance Company Name : NEURON - CN GN+ GNP | Policy Number : |

**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 given above are ture. I hereby consent to and authorise the medical provider, health professional or other relevant medica provide and discuss any health/treatment details, medical records or discharge arrangements (past and present) with and

provide and discuss any health/treatment details, medical records or discharge arrangements (past and present) with and /or Third Party Administrator. I agree that a copy of this consent shall have the validity of the original.

Signature :



Date : 09-01-2025

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(N

Patient Signature | Save | Print

**Previous History**

| Date | Doctor | Previous Form |
|---|---|---|
| 03-Dec-2022 | Out patient | |