



## Neuron Direct Billing Claim Form - General

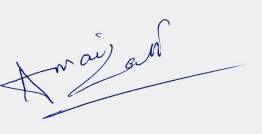
### Section A - Details of Member/Patient

|                                            |                                                  |
|--------------------------------------------|--------------------------------------------------|
| Patient's Name and Address : NAYA ZAGHLOUL | Membership Number from your card : 6870817668702 |
|                                            | Date of Birth : 07-Sep-2019                      |
|                                            | Tel Number : 0521888960                          |
|                                            | 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: <b>J02.9 - Acute pharyngitis, unspecified, R50.9 - Fever, unspecified</b> |                 |                      |
| 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                                                                                            | Consultation Gp | General Consultation |
|                                                                                              |                 |                      |

### Section C - Treating Physician/Dentist

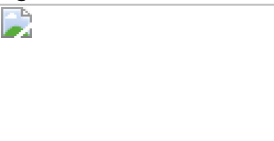
|                                                                                                                                               |                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 : 0561012068                                                                                                                                                                                                                                                                   |
|                                                                                                                                               | Fax Number :                                                                                                                                                                                                                                                                              |
| Signature<br>                                               | Medical Practitioner's Stamp:<br><div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>Dr. Amaizah Ishtiaq</b><br/>           General Practitioner<br/>           DHA: 98486553-001<br/> <b>CITICARE MEDICAL CENTER</b><br/>           DUBAI - U.A.E         </div> |
| Date :                                                                                                                                        |                                                                                                                                                                                                                                                                                           |

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

|                                      |                        |
|--------------------------------------|------------------------|
| Insurance Company Name : NEURON - GN | Policy Number : 514915 |
|--------------------------------------|------------------------|

### 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 true. 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<br> | 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)

