DENTAL CLAIM FORM - PROVIDER DIRECT BILLING

Section 1 - Details of Member/Patient

Patient Name and Address :	SYLVETTE DEE APRIL BOJOS GORON	**Member Neuron ID:**	TPA001
		Emirates ID :	DHA-P-84724128
		Date of Birth :	25-Apr-1989
Facility Name (In-Network Provider):	TPA001	**Member Tel Number:**	
Insurence Name:	NEURON - GN	**Member Mobile :**	0503824691

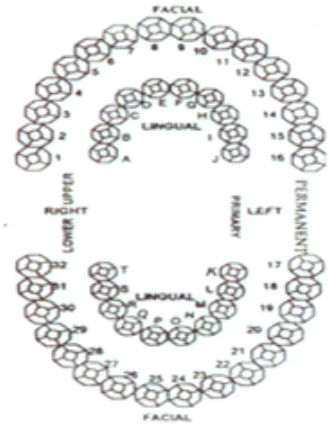
Section B -Medical Section

(to be fully completed by treating dentist - involved tooth numbers must be marked on chart also)

Diagnosis Requiring Treatment :	K05.10 ,K05.00 pericoronitis tooth #32
Presenting Complaint/s :	pain in the lower right side
History :	2 days ago
Clinical Details :	swelling and redness around tooth #32 partially erupted
Treatment Plan :	scaling and polishing all teeth and more irrigation for #32 gum

Section C - Dental Treatment Details

DENTAL PROCEDURE	TOOTH # (UNIVERSAL NUMBERING)	SURFACE	PROCEDURE CODE	COST AS PER AGREED TARIFF
CONSULTATION	#32		D0150	
X-RAY				
AMALGAM/COMPOSITE/TEMPORARY FILLING				
EXTRACTION				
SCALING/PROPHYLAXIS				
OTHERS(PLS SPCIFY)				
TOTAL COST(AS PER AGREED TARIFF)				



PLEASE MARK INVOLVED TOOTH CLEARLY IN THE CHART (CLAIM WILL DENIED IN CASE DISCREPANCY)

Section - D Treating Dentist

I declare that I am the patient's treating Dentist, and that the particulars given are to the best of my knowledge true and correct	Tel Number	0563232355
	Fax Numbrer :	IMCA1003
	Treating Dentist Stamp :	Dr. Abdulrahman Al Tekreeti General Dentist DHA No: 84724128-001 PESHAWAR MEDICAL CENTER LLC DUBAI - U.A.E.

Patient Declaration and Consent

I confirm I am the patient's or guardian (if the patient is under 16 years of age) and wish to claim benifits and declare that all the particulars given above are to the best of my knowledge true and correct.In respect of any medical claim. I hereby consent to and authorize the medical practitioner, health proffessional or other relevent 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 thar a copy of this consent shall have the validity of the original.	Signature

Date: 22-May-2023