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Claim Form - Provider Direct Billing

Please indicate nature of claim ☐ Medical Claim ☐ Dental Claim

Section A - Details of Member/Patient

Patient's Name and Address	Membership Number from your card
Tooba Saleem Sayyed	58IP6059354559701
	Date of Birth : 07-Jan-1994
Facility Name (in-network Provider) : DHA-F-0047965 : Peshawar Medical Center (Ar	Tel Number :
Insurance Name : Cigna	Fax Number :

Section B - Medical Section

(To be fully completed by treating physician or dentist - all boxed must be completed in block capitals)

Condition/s requiring treatment	28 years. G1P1+0. C/O Absent periods
Presenting complaint/s	for 3 months. Preg test Negative.
History	H/O irregular periods before. Per period
Clinical findings	every 45 days, but now no period
How long has the patient been aware of the complaint/s?	for 3 months. Also, C/O lower
Date first consultation with any practioner for this/these condition/s?	abdominal pains.
Planned treatment and prognosis	Consultation, genac USG, FSH, LH, TSH, Prolactin.

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
	Fax Number
Signature Dr. Rekha Mathur Date 13/6/22	Medical Practitioner's Stamp: Dr. Rekha Mathur, Obstetrics and Gynecology, DHA No: 00167982-005, PESHAWAR MEDICAL CENTER LLC, DUBAI - U.A.E.

Other insurer's details

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

Insurance Company Name	Policy Number

Patient's Declaration and Consent

cl confirm I am the patient (or the patient's parent or guardian if the patient is under 16 years of age) and wish to claim benefits 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 authorise the medical practitioner, 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 13/06/2022

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, PO Box 72071, Dubai, UAE**

Claim Number (Neuron use only)