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
Mugdha Kolhe	8382192502
	Date of Birth : 12-Jan-2012
Facility Name (in-network Provider) : DHA-F-0047965 : Peshawar Medical Center (Ar	Tel Number :
Insurance Name : Aetna	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	Fever 102 F
Presenting complaint/s	
History	Sore Throat NKDA
Clinical findings	Cough Congestion
How long has the patient been aware of the complaint/s?	
Date first consultation with any practioner for this/these condition/s?	
Planned treatment and prognosis	Antibiotics ~~SEE~~ Inj Panadol

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 Date / /	Medical Practitioner's Stamp

Dr. Sajid Sanaullah Khan
General Practitioner
DHA No: 05758224-001
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

cI 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 MK Date 12/06/2022

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)