Dental Claim Form - Provider Direct Billing

Section A - Details of Member/Patient

Patient's Name and Address	Membership Number from your card
Dima Aziz Haider Darwish	65157114224
	Date of Birth : 01-Jan-1976
Facility Name (in-network Provider) : DHA-F-6951075 : DENTISTR	Tel Number :
Insurance Name : ENAYA	Fax Number :

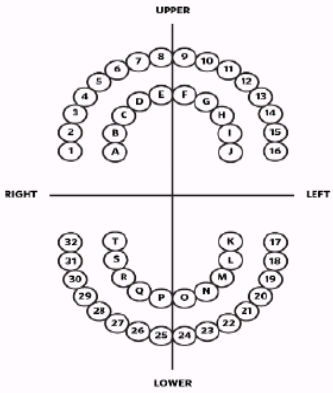
Section B - Medical Section

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

Diagnosis requiring treatment
Presenting complaint/s
History
Clinical details
Treatment Plan

Section C - Dental Treatment Details

DENTAL PROCEDURE	TOOTH# (UNIVERSAL NUMBERING)	SURFACE	PROCEDURE CODE	COST AS PER AGREED TARIFF
Comsultation				
X-ray				
Amatgam/Composite/Temporary F				
RCT				
Extraction				
Scaling/Propylaxis				
Others (Pls Specify)				
Total cost (as per agreed tariff)				



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

Section D - Treating 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 Signature Date / /	Tel Number Fax Number Treating Dentist Stamp

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 / /

The claim form should be submitted within 90 days of start date of the treatment through DHPO 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. Claim will be considered null and void if not billed as per agreed tariff between provider and Neuron LLC - Dubai. Claim will be settled as per the agreed tariff in the signed contract with Neuron LLC after medical and financial evaluation.