Claim Form - Member Reimbursement

neuron

If you have any questions regarding this form or any other aspects of your cover please call Neuron on 800 44 08

Details of Member/Patient

Member's Name	Membership Number from your card
Nikhil Balchandani	
	Claim Number
	Date of Birth 29 / 05 / 1994
Email Address	Tel Number
Patient's Relationship to Member	Fax Number

Medical Section (to be fully completed by treating physician or dentist - all boxes must be completed in block capitals)

Medical Practitioner's Name and Address	Date symptoms first noticed by patient
Dr. Priyanka Kiran	1/3/2024
	Tel Number
	Fax Number
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 9 / 3 / 2024	Medical Practitioner's Stamp Dr. Priyanka Kiran General Dentist DENTISTREE DHA-00148697-002 DENTISTREE DENTAL CLINIC
Medical condition requiring treatment K05.00 Acute gingivitis plaque induced	
Please give date on which your patient first presented to any doctor for this condition 9/3/2024	
Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates. Please also advise any further treatment planned Bleeding gums. food lodgement Rx D1110 - Scale and Polish -	

DENTISTREE Tel. Nr.: 04 129935 DENTISTREE DENTAL CLINIC

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

I 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 along with all original receipts/invoices as per the policy membership agreement. 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

Date Received (Neuron use only)