Dental Claim Form - Provider Direct Billing

Section A - Details of Member/Patient

Patient's Name and Address	Membership Number from your card
Ayansh Heda	52GM2522464874803
	Date of Birth : 05-Apr-2015
Facility Name (in-network Provider) : DHA-F-6951075 : DENTISTR	Tel Number :
Insurance Name : Cigna	Fax Number :

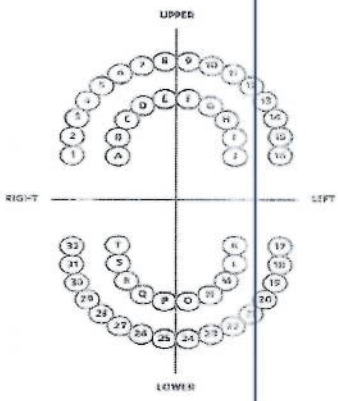
Section B - Medical Section

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

Diagnosis requiring treatment	K05.00 - Acute gingivitis, plaque induced.
Presenting complaint/s	Bleeding gums.
History	
Clinical details	Calculus.
Treatment Plan	Consultation, X-ray.

Section C - Dental Treatment Details

DENTAL PROCEDURE	TOOTH# (UNIVERSAL NUMBERING)	SURFACE	PROCEDURE CODE	COST AS PER AGREED TARIFF
✓ Consultation			D0140	135
✓ X-ray OPG.			D0330	92.16.
Amalgam/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 R. Desai Date 4 / 5 / 24.

Dr. Rutul Desai
General Dentist
DHA-44339326-001
DENTISTREE DENTAL CLINIC

Tel Number
Fax Number
Treating Dentist Stamp

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 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.

Eligibility Details

AYANSH HEDA,784-2015-9264315-5
Effective from : 01-Jan-2024to 31-Dec-2024at Cigna
Required Treatment is Dental
Reference No: R-00000238945840
Request Date: 04-May-2024 12:10:39

neuron

Eligible

Comprehensive Network [Applicable Tariff: Comprehensive Network]

- Referral required : **No referral required for specialist consultation**
- Copay 20% applicable for :Class II
- Copay 50% applicable for :Orthodontics Treatment, Class III

Approval Requirements

Approval required for all treatment related to:
Acute Drugs, Class I, Class II, Class III, Orthodontics Treatment

Attachments

- Pre-Auth protocols
- Consultation / Claim Form
- Prescription Form

Ask for Authorization

Referral Document