Dental Claim Form - Provider Direct Billing

Patient Name and Address	:	Alston Rebello	Member Neuron ID	:	1234
			Emirates ID	:	784-1991-2906159-3
			Date of Birth	:	1996-06-20
Facility Name (In-Network Provider)	:	VISION MEDICAL & DENTAL CENTER (Abu Dhabi)	Member Tel Number	:	065634883
Insurence Name	:	ADNIC	Member Mobile	:	971506245967

Section B -Medical Section

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

Diagnosis Requiring Treatment :	rty
Presenting Complaint/s :	rty
History :	rty
Clinical Details :	rty
Treatment Plan :	rty

Section C - Dental Treatment Details

DENTAL PROCEDURE	TOOTH # (UNIVERSAL NUMBERING)	SURFACE	PROCEDURE CODE	COST AS PER AGREED TARIFF	
CONSULTATION	rty	rty	rty	rty	
X-RAY	rtyrtyrty	rty	rty	rty	
AMALGAM/COMPOSITE/TEMPORARY FILLING	rtyrt	rty	rty	rty	
EXTRACTION	yrtyrty	yrty	rty	rty	
SCALING/PROPHYLAXIS	rtyrty	rty	rty	rty	
OTHERS(PLS SPCIFY)	rtyrty	rty	rty	try	
TOTAL COST(AS PER AGREED TARIFF)				rty	

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the above-mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy or any other person who has provided medical services to me to furnish any and all information with regard to any medical history, medical condition, or medical services and copies of all medical and Clinic records.

Patient's Signature
2024-04-27

Date

Pharmaceuticals (to be filled by treating doctor only)