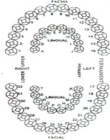


Dental Claim Form - Provider Direct Billing					
Patient Name and Address	:	Alston Rebello	Member Neuron ID	:	1234
			Emirates ID	:	784-1991-2906159-3
			Date of Birth	:	1996-06-20
Facility Name (In-Network Provider)	:	VISION MEDICAL & DENTAL CENTER (Abu Dhabi)	Member Tel Number	:	065634883
Insurence 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 :	rtv
Presenting Complaint/s :	rtv
History :	rtv
Clinical Details :	rtv
Treatment Plan :	rtv

Section C - Dental Treatment Details

DENTAL PROCEDURE	TOOTH # (UNIVERSAL NUMBERING)	SURFACE	PROCEDURE CODE	COST AS PER AGREED TARIFF	
CONSULTATION	rtv	rtv	rtv	rtv	
X-RAY	rtvrtvrtv	rtv	rtv	rtv	
AMALGAM/COMPOSITE/TEMPORARY FILLING	rtvrt	rtv	rtv	rtv	
EXTRACTION	rvrtvrtv	rvrtv	rtv	rtv	
SCALING/PROPHYLAXIS	rtvrtv	rtv	rtv	rtv	
OTHERS(PLS SPECIFY)	rtvrtv	rtv	rtv	try	
TOTAL COST(AS PER AGREED TARIFF)				rtv	

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)