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neuron نيورون

Dental Claim Form - Provider Direct Billing

Section A - Details of Member/Patient

Patient's Name and Address	Membership Number from your card
Jood Mohammad Yousef Alrahma	4000200166903
	Date of Birth : 16-Sep-2015
Facility Name (in-network Provider) : MOH6811 : Oxygen Medical C	Tel Number :
Insurance Name : Dubai Electricity and Water Authority	Fax Number :

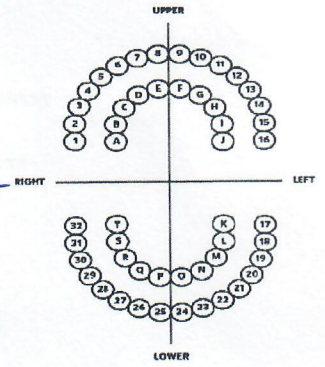
Section B - Medical Section

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

Diagnosis requiring treatment	Pulpotomy treated tooth need SSC #I, J
Presenting complaint/s	K08.530
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	#I, J		D0220	31.47
Amatgam/Composite/Temporary F				
~~RCT~~ SSC	#I, J		D9930	237.12x2
Extraction				474.24
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	Tel Number
	Fax Number
Signature شوكتالخولي Date / /	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 professiona! 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.

OXYGEN MEDICAL CENTER LLC
د. شوكت احمد زكي ابوالنجاد الخولي
Dr. Shawkat Ahmed Zaky Abouelnaga Elkouly
Dentist Lic. No. D52147