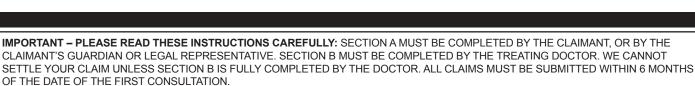
NEURON GENERAL CLAIM FORM

Please complete this form in block capitals using black ink and send your completed claim form and receipts to reimbursementclaims@neuron.ae



neuron

SECTION A: TO BE COMPLETED BY THE CLAIMANT OR THE CLAIMANT'S GUARDIAN OR LEGAL REPRESENTATIVE

Full name of claimant:	Date of birth (DD/MM/YYYY):
Claimant's Neuron ID:	Sex: 🗆 Male 🗅 Female
Telephone:	Fax:
Email:	
Please state the name and address of your regular doctor or cl	inic:
Name:	

Address: Telephone:

Fι

Email:

2. DETAILS OF THE CONDITION BEING TREATED

Please describe your symptoms:

When were you first aware of your symptoms?

When did you first consult a doctor with regard to these symptoms?

What is your doctor's diagnosis?

Have you ever suffered from this or any related condition before? DYES D NO If YES, when did you suffer from this or the related condition?

Is your claim related to injuries sustained in an accident? YES NO

3. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the fully itemised accounts including copies of the credit card terminal receipts if you have paid by card. If the total value of

your submission is over AED1,000, you must submit the originals to Neuron by post.

Date(s) of treatment:	Details of the bills you have enclosed for reimbursement:	Please state currency and amount paid:

4. ACCOUNT DETAILS FOR REIMBURSEMENT

PAYMENT TO YOUR BANK ACCOUNT

Currency in which you would like to be reimbursed:

If you have previously submitted a claim, are your payment details the same? UYES UNO UNOT APPLICABLE

If YES, please confirm the last 4 digits of your account number:

If NO, please provide your account details below:

Bank name and address:

Account holder name(s):

IBAN number*:

* BIC and IBAN details are necessary for all transfers to European and UAE bank accounts.

□ PAYMENT BY CHEQUE NB. Payment can only be made in UAE Dirhams.

Payee Name



and then go to part 5.

BIC Number*:

5. DECLARATION AND AUTHORISATION

Do you have any other insurance cover?

□ No, I have no other health insurance cover □ Yes, I have other health insurance cover with:

I hereby give Neuron LLC authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s and financial payment information. I also authorise any doctor of medicine, hospital or other health professional who has attended or examined me, to furnish Neuron LLC and/or their authorised representative any and all information with respect to illness, medical history, consultation, prescription, medical investigations or treatment and copies of all hospital records and/ or medical records.

Name of claimant:

Date of birth (DD/MM/YYYY):

Signature of claimant (or guardian):

SECTION B: TO BE COMPLETED BY THE CLAIMANT'S DOCTOR

1. PATIENT DETAILS

Patient's full name:

Date of birth (DD/MM/YYYY):

Was the patient referred to you? 🗆 YES 🗅 NO If YES, please state the name and contact details of the referring doctor:

2. DATES

1. Please confirm the date the patient first registered at your facility (DD/MM/YYYY):

2. On which date did the patient first consult you for this particular condition (DD/MM/YYYY)?

3. Please give a short description of your patien's symptoms or injuries, if they have suffered an accident:

4. In your professional opinion, on what date would the patient have been aware of their symptoms? (DD/MM/YYYY)

5. Has your patient previously suffered from this or from any related condition? I YES I NO

If YES, please give full details of the previous condition/related condition, and the dates on which it first occurred:

3. YOUR DIAGNOSIS

What is your clinical diagnosis?

4. YOUR TREATMENT PLAN

Please provide a treatment plan including details of test performed and medications currently being prescribed to the patient:

6. DECLARATION BY DOCTOR

I declare that I am the patient's treating doctor, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature:		
Print your name and address:		
Telephone:	Fax:	
Email:		



Neuron LLC I.T Plaza Building, 6th Floor, Dubai Silicon Oasis, PO Box 72071, Dubai, UAE

reimbursement@neuron.ae www.neuron.ae



Plans designed by William Russell Ltd

Global Health plans are designed by William Russell Ltd and are issued and insured by Dubai Insurance psc who are licensed by the UAE Insurance Authority under registration number 4

Date:

Sex:
Male
Female